State of Maryland / Department of Health and Mental Hygiene 2006 28001 Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 3 2006 Physician BRUSILOVSKY 6:35 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/13/1920 Birthplace (State or Foreign Country)
 UKRAINE 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🕡 F 213-33-2588 85 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 X Yes 2 □ No Completed by Funeral Director BALTIMORE MD N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 5715 PARK HEIGHTS AVENUE #414 21215 itams 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 14. Race - American Indian, treumatic event, the Madical Exeminer Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: if item 27 is marked other than "naturel", or ita 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: Specify 3 X Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BACTERIAOLOGIST MEDICINE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NEZNAMOV MARKMAN RACHEL DAVID ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7207 VALLEY COUNTRY COURT #A-1 BALTIMORE, MD 21208 YELENA BRUSILOVSKY / DAUGHTER other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō Department in important: if eny injury or once. 4 □ Donation 5 □ Other (Specify) ARLINGTON CHIZUK AMUNO 09/04/2006 BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. Matt Cevin 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ~ Due to (or as a consequence of Examiner anding physicien and K The jaw requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy to Month Year Day 4 Pregnanf at time of death 5 Other (specify) P.O. 9 Unknown cete has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ģ 1 Tyes 2 JUN6 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 46 1 Yes 2 No Division of Vital Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/OutpatienI 3 DOA Other: 1 Yes 2110 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To (his 28a. Date of Injury (Month, Day Year) After th funeral 27. Manney of Death 28b. Time of 28c. Injury af Work? 28d. Describe how injury occurred 1 Natural ospital ...
4 hours after dea...
-rei Director: After 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after
To the Funeral Dire
completely filled in by Medical 29a. Certifier 1 Critifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 50 mfcm12013,2006 and address of person who completed cause of death (Item 23a) (Type, Print) Yourd of down T 6-mag 32. Segistrar's Signature 31. Date filed (Month, Day, Year) State 2006 06 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 2006
Registrar Amend item#10c,perFh,28f,perMD,g859,96/2006
Reg. No. 28002 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Charles Boyd 24 1546 FM 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Bulliume / vaima University of Maryland If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 142 M 2□ F 60 218-42-3860 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Anne Annapolis 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21401 USA 1810 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, efc. 11. Marital Status 1 ☐ Never Married 2 → Married 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. Specify: BLACK 3 Widowed 4 Divorced

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haelth and Mantal Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f ehrmone, injury or other traumatic event, Its Medical Control of the page 1.

Physician

/Medical

Examiner

Director

Funeral

Funeral

Director

Physician /Medical Examiner

> attending physician and for usa as tha burial-transit ٩

> > Certification;

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Greens

SEP 0 6 2006

5 Pending

investigation 6 Could not be determined

To the Hospital or Attending Physician: Tha law requiras that tha death cartificata ba axacuted within 24 hours after death.

To the Funeral Director: Af Medicai

Division of Vital Records, P.O. Box 68760

	O Tridoned + Directed	real of Dates.				221011
ieted	15. Decedent's (Specify only highest g		16a. Decedent's Usual Occu (Give kind of work done life, DO NOT use retire	during most of working	16b. Kind of Busine	ss/Industry
Be Completed t	Elementary/Secondary (0·12)	College (1-4or 5+)	ELECTRICIAN	.,	US NAVAL	ACADEMY
To Be C	17. Father's Name (First, Middle, Later FRANK W. BOYI	*		18. Mother's Name (First, Mid-		
-	19a. Informant's Name/Relationship CATHERINE L.			and Number or Rural Route Number		
	20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	□Removal from State	Place of Disposition (Name of cometery, crematory or other pla OWNSVILLE VETEI	RANS 8 31 2006	20c. Location - City	or Town, State
	21. Signature of Finanti Service Liv	LARRY REESE	821 WEST	oss of Facility WM. REES: ST. ANNAPOLIS,	E & SONS MO	RTUARY, P.A.
	23a. Part - Enter the disease, or co shock, or heart failure List on	mplications that caused the death ty one cause on each line.	th. Do not enter the mode of dyi	ng, such as cardiac or respirator	y arrest,	Approximate Inferval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	w	umatic brain	injury	1	Onsat and South
xaminer	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o		CERTIFICATION APPROVED BY ME	DICAL EXAMINER	
dical E		d		CERTIFICATION		
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at fime of de	al death 3 Ectopic pregnanc		23d. Date of Month	delivery Day Year
ed by Ph	Part II. Other significant conditions Service disord Alcohol abus	•	sulting in the underlying cause gr		11	e to the cause of death?] Probably 4 ∐Unknown
Complet	Alcohol abus	e		24a. W au pe 1 □ Ye	ortormed? prior	e autopsy findings available to completion of cause of n? Yes W No
Be	25. Was case referred to medical examiner?	Hospitals M	\ o	26. Place of Death Check on	ly one)	
0	1⊿XYes 2 □ No	Hospital: 1 Inpatient 2 □ I	ER/Outpatient 3 □ DOA	ner: 4 Nursing Home 5 R	esidence 6 Other (5	Specify)

State Registrar 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1100 AM

28c. Injury at Work?

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number P13154

1 🗌 Yes

2 No

28d. Describe how injury occurred

1810 Whiten Ct

Fall down stairs

28f. Location (Street and Number or Rural Route Number, City or Town, State) Apparolis

29d. Date signed (Month, Day, Year)

8-24-2006

Annapolis MD

28a. Date of Injury (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5%.

- 20-2006

Baltimore

32 Pegistrar's Signature

home

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 28003 State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** FRED BROWN JR. 3:37PM 28,2006 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Clen Burnice
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day. inne Arundel Balt, more Washington Medical Cent 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or **Funeral** 1□M 2□F Yrs. 50 ARKAŃSAS **Director** 213-64-0787 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Items 23a or 28a-f ehov th and Mental Hygiene. 27 is marked other than "naturel", or Items 23a or 28a-f eho treumatic event, tre Medical Examinar must be notified al 1 XYes 2 No Directo MD. ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 N. CRAIN HWY. APT 941 21061 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) -12-COOK -2-DAVES PUB permit. Pages 1 end 2 should be file. Department of Health and Mental Hyg Important: if Item 27 is marked other eny injury or other treument. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FRED BROWN, SR. HATTIE ADAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VERNITA L. TYLER-BROWN(SISTER) 109 CONLEY DR. ANNAPOLIS, MARYLAND 21401 Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State BESTGATE MEMORIAL PARK 9-5-2006 ANNAPOLIS MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 21. Signature of Funeral Service Licensee LARRY REESE Lavry 821 WEST ST. ANNAPOLIS, MARYLAND 21401 D. Keese MO0483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PNEWMON:17 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 1 ☐ Yes 20 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospitat: 1 ☐Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ☐ ER/Outpatient 3 ☐ DOA hours after death.
Inerel Director: After this
y filled in by the funeral dir this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification; 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funerel C 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one)

DHMH 17 Rev 1/2001

Grown, Fred

Box 68760

Division of Vital Records, P.O.

Registrar

31. Date filed (Month, Day, Year) SEP 0 6 2006

29b. Signature and title of certifier

BALTIMONE

WHSUITETO MEDICAL 32. Registrar's Signature

30. Name and address of woon who completed cause of death (Item 23a) (Type, Print)

00 53703

29d. Date signed (Month, Day, Year) August 28, 2006

GLET BUZNIE MS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 28004 State of Maryland / Department of Health and Mental Hygiene 2006For State Registral Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 10:361 **Physician** September 200 HELMINA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NIA BALTIMORE HOPKINS HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. 5UNE 3,1961 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□M 201 Yrs. MARYL 220-80-0876 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 72 hours after death with the Maryland 10a. State 10b. County traumatic evant, the Mudical Examiner must be notified at 1 XYes 2 □ No BALTIMORE Director MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number S.A 3547 Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 25 Married BLACK 1 ☐ Yes 2 🗷 No ō Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) JOHNS HOPKINS BILLING CLERK YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental I CARPENTER BUNDY JAMES ဥ Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLARENCE S. CHESTER (HUSGAND) 3547 ELMLEY AVE, BALTIMORE, MD 21213 Health tam 27 Important: If itam any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of t 1

Burial 2 □ Cremation 3 □ Removal from State PARK 09-07-2006 BALTIMORE, MARYLAND MEMORIAL ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

1986 2. Fulfor 21. Signature of Funeral Service Licensee JR. Funeral e BAHO, MI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death BREAST CA Immediate Cause (Final METASTATIC SIMONTH Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): **burial-transit** Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 ☐Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? I ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 R/Outpatient 3 DOA 1 Inpatient 0 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Acident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 T Homicide

Division of Vital Records, P.O. e Hospital or Attending Pl 24 hours after death. a Funaral Diractor: After ti

within 24 hor To tha Funs completely fi

29a. Certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and

29d. Date signed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month, Day, Year)

SEP 0 6 2006



State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 28005 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** AUGUST 6:20 PM 28, 2006 THERESA MARGIE CHERRY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hos paltimore VINCU BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🗙 F Yrs. 08/11/1949 215-52-4446 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Mode 1 ?? is marked other then "natural", or items 23a or 28a-f sho: traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Directo MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3624 GLENGLYE AVE. 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ➡ No Specify: BLACK Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH NURSING HOSPITAL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental ပ္ UN CORRINE BRANNON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 3624 GLENGLYE AVE., BALTIMORE, MD 21215 VALERIE COTTMAN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 5600 O DONNELL ST. 20a. Method of Disposition permit. Pages
Depertment of I
important: If ite
any injury or of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/06/2006 BALTIMORE, MD 21224 CARMEL CEMETERY 21. Signature of Funeral Service 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL HM. 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part. Eiter the diseas / r complications that shock, or heart failure / ist only one cause on eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Compartment Syndrone **Physician** Abdomina /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events ue to (or as a consequence of) Examine sicien and \ and The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical attending phys for use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day signed by the at d be detached fo 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificete 1 ☐ Yes 2/2 No 1 Tes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဥ 1 Tes After thi 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director; / completely filled in by the f 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide ò 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certified 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. BELUE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Itimore,

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O. Box 68760.

of Vital Records,

6-03577 tephanie Chalic	e Co	oleman Sta			d / Depa	artment o	of He	ack Indeli ealth and			giene					
	F	- For State Registrar			Cer	rtificate d	of De	eath				eg. No	20	Q	$\frac{28}{1}$	100
Physicia Medical Examin	er	1. Decedent's Name (First, Middle Steph	anie		Colema:	n					2. Date of Dea Month May 27, 2	Day 2006	Year		Time of Death 0555 hrs	,
		4a. Facility Name (if not institutio 4111 Pennsylvania Av	_	et and numi	ber)		1	City, Town, or Li uitland	ocation of	Death		- 1	c. County of De Prince Geor			
Funeral	4	5. Social Security Number	6. Sex	7.	. Age (In yrs. I	ast birthday)		Under 1 Year	If Under	24Hrs.	8. Date of Bi		/DD/YYYY) 9. I	Birthpl	ace (State or	
Director		579-06-1039	1 M	2 X F	2	4 Y	rs.	Months Days	Hours	Min.	August	27		eign Count	w Wash,	DC.
any	ŀ	Usual Residence of Decedent 10a. State 10b. County			10c. City	Town or Loc	ation							10	d. Inside City	Limits
	٦	D. C.			Wa	shingt	on,	D.C.						1	X Yes 2	No
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itens	Funeral	11. Marital Status 1 X Never Married 2 M	arried 12.	Armed Ford	ces?	13. 1	f Yes, s	specify Cuban,	Mexican,	Puerto F	Rican, etc.)		White, etc		, , , , , , , , , , , , , , , , , , , ,	·
after de	by F	3 Widowed 4 Div	orced or D	Yes s, Give Yeer ates:	2 X No	1	Yes	s 2 X No	specify:				Specify: I	31a	ck	
hours :	ed b	15. Decedent's Education (Spe	cify only hig	hest grade				Jsual Occupation of working life. I				16b.	Kind of Busines	ss/Ind	ustry	
136 hin 72 e. than "	Completed	Elementary/Secondary (0-12) 10th	`	College (1-4	FOI 5+)		Ca	shier					Privat	:e		
5-00 led wit tygien other		17. Father's Name (First, Middle,	Last)			<u> </u>		1	8.Mother's	Name	(First, Middle,	Maide	n Surname)			
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hygene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	B	Michael Burre 19a. Informant's Name/Relations		Drint \		10h Mai	ling Ad	Idrass (Stroot			Colen		City or Town, St	ate 7	in Code)	
s, MD 2 and 2 shoul lealth and M tem 27 is m traumatic	٩	Sheila Coleman			ther	- 1							on, DC.		20019	-
e, N l and 2 Health item 3	1	20a. Method of Disposition			20b.		osition	n (Name of cem	_		Date		Location - City		wn, State	
More Pages 1 lent of H int: If i	4 Donation 5 Other Specify Metropolitan crematory 9/1/2006 Alexandria, VA.										VA.	_				
Baltimore, permit. Pages I at Department of He. Important: If ite	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes 5538 Marlboro Pike															
Physician	-	23a. Part I. Enter the disease, or	complicate	ons that cau	used the death	h. Do not ente	er the n	node of dying, s	uch as ca	For	estvil	He.	Md. 2	207	Approximate I	
/Medical		failure. List only dec cause Immediate Cause (Final disease	on each lin	ie.	o and Cutti										Between Ons Death	
Zammer		or condition resulting in death)		to (or as a c	consequence	of):										
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		to (or as a	consequence	of):								\neg		
ed sit	Examiner	(Disease or injury that initiated events resulting in death) Last		to (or as a d	consequence	of):										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		UNPENDED	dAN	MENDED							-			1		
760, cate be	/Mec	IF FEMALE: 23b. Was decedent pregnant in t		_	utcome of pre-	gnancy						2	3d. Date of deli	-	. V-	
Box 68760, e death certificate be ex the attending physician ed for use as the burial	Physician/Medical	past 12 months?	4	Live bir Pregna	th int at time of	5	Fetal of Other	death 3 (Specify)	Ectopic	pregna	ncy	1	Month	Da	y Ye	iai
b.O. Bo. that the deat ned by the at detached for	hys	1 Yes 2 No 9 V Un	3	Unknov	100	raculting in th	no unde	orlying cause di	von in Pa	rt I	23e Did	tobacc	o use contribute	e to th	e cause of dea	ath?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach		Part II. Other Significant condi	nons con	induling to	death but not	resulting in ti	ie unu	errying cadse gi	VCII III I U				✓ No 3			
rds,	Completed							_				opsy	prior	to cor	psy findings a npletion of cal	
Recc The lav	E O										perf 1 ✓ Yes	formed 2		h? Yes	2	No
cian:	Bec	25. Was case referred to medica examiner?	Hospi	tal		1			of Death (D-+i	danas 6 2 10	Mb 6	2	
f Vi Physi eral dir	٤	1 ✓ Yes 2 No 27. Manner of Death	1,300	29a Date o	patient 2	ER/Outpati			y at Work		g Home 5 28d. Describe		dence 6 C	mer.	Scene	
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ivisi or Att ufter de Directo	Certification:	3 Suicide 6 Cou	stigation L					factory, office b	uilding, etc	- 1	or Town,	State)				er, City
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To To	ğ	29b. Signature and title of certifi		manner sta	ateu.			29c. License				-	d. Date signed		h, Day, Year)	
		(Dante	leen	D				O.C.I	И.E.			М	ay 27, 2006 			
H		30. Name and address of person Laron Locke MD.			e of death (Ite Examiner		nn S	treet, Baltin	nore. M	D 212	01					
St	ate	31. Date filed (Month, Day, Year,			gistrar's Signa		7	9 :								
Regist	rar	SEP 0 6	2006	Man	Come of	K for	gar.	الحري								

ORIGINAL

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Robert Henry Cor		- For State	Sta	te of Maryla			ment of			Menta	al Hyg		N-	20	06	2800		
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Medical Examin	er			Conner Sr								Month Septembe				305 hrs		
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Funeral		5. Social Security N		S. Sex	7. Age (In	yrs last	birthday)	If Under	1 Year	If Under	24Hrs.	8. Date of Bir	th (MM/DD			(State or		
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, MD and 2 sho ealth and tem 27 is		20a. Method of Dis						of Disposition (Name of cemetery, Date 20c Location - City or Town, State							State			
nore ages 1 nt of H	beautiful Pages 1 and 2 should be filted within 12 hours after death with the Maxyland Department of Health and Mental Hygiene 10 and 2 should be filted within 12 hours after death with the Maxyland Department of Health and Mental Hygiene 11 manual feetent than "martiner must be not transmitter event the most of the manual feetent than "martiner must be not the most of the manual feetent than "martiner must be not stated on the manual feetent than the manual					Che	ematory or oth .sapeak	ner place) e Cre	emate	ory	09.	-06-200	10d. Inside City Limits 1					
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Division tal or Attendir rs after death. al Director: A	Certification:	2 Accident 3 Suicide		stigation 28e. Pla	ace of Injury	- At ho	me, farm, stre	et, factory,	office b	uilding, et	c.	28f. Location or Town,		d Number	or Rural R	oute Number, City		
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10		Mary G. R		Deputy Chief	Medical Registrar's				otreet	, Baitim	ore, IV	D 21201						
S	tate	31. Date filed (Mo	SEP 06	2006	ALELAR.	L	1. 15/1	esse										

Registrar

State 31. Date filed (Month, Day, Year) 2006

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State of Manyland / Department of Health and Mental Hygiene 2006

December 1 Dec		1 - For State Registrar		aryland / Dep <i>Ce</i>	artment of F	lealth and M Death		Reg. No.	U6	
As facility Name of Port centuring you served and numbers of Cooking Name of Port Name	Physician	Control Control)	Camphell		Month	Day	Year	
217-66-3488 NA Baltimore 10, Scross 10, Clark Town or Leasing 10, Scross 10, Scross 10, Scross 11, Maria Slave 11, Maria Slave 11, Maria Slave 11, Maria Slave 12, Was Deposited from 11 2. 12, Was Deposited from 12 2. 13, Maria Slave 11, Maria Slave 11, Maria Slave 12, Was Deposited from 12 2. 13, Maria Slave 14, Maria Slave 15, Scross 15, N. Patterson Park Ave. 12, Was Deposited from 12 2. 14, Maria Slave 15, Scross 15, N. Patterson Park Ave. 16, Scross Slave 16, Scross or Maria 17, Maria Slave 18, Maria Slave 19, Maria Slave 19, Maria Slave 10, Scross or Maria 10, Maria Slave 10, Scross or Maria 11, Maria Slave 11, Maria Slave 12, Was Deposited from 12 2. 13, Maria Slave 14, Maria Slave 15, Scross 15, N. Patterson Park Ave. 16, Scross or Maria 18, Maria Slave 19, Maria Slave 19, Maria Slave 10, Maria	/Medical	4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, o		8	4c. County	of Death	6:58p
10a. State 10b. County 10c. City, Town on Location Selection 10d. Decompt 10d. Decom		Social Security Number 6.	Sex 7. Agr	Yrs.	If Under 1 Year	If Under 24 Hrs.	8. Date of Birn (Month, Da	th 12, Year) 23 57	9. Birthp Cour	place (State or Foreigntry) Md.
Comparison Com	Aaryland I show	10a. State 10b. County				-			1	
Compared to the control of the con	with the Moral of the De notified	10e. Street and Number	- D-vds 3sss	<u></u>	10f. Zip Code			-		ntry?
Section Part	or Itema 23	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 Dyes 2 1	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Rad Bla	ce - Americ ck, White,	etc.
Sequentially list conditions Figure 1 Figure 2 No. 3 Probably 4 Morkow 1 No. 2 No. 3 Probably 4 Morkow 2 No. 3 Probably 4 Mo	n "naturel", Audical Ex.	15. Decedent's (Specify only highest s	Education trade completed)	(Giv	edent's Usual Occup	pation during most of work d)	ing		171	
Section Process Proc	Hygiene. other the	10th grade			sekeeping	18. Mother's Nam	e (First, Middle	-		s, Inc.
So whended of Deposition Amount of the contributing to death but not resulting in the underlying cause given in Part I. 20. If I was to great a consequence of: 21. Separating of French Service Licenses 22. Name and Address of Facility March F.H. East 23. Separating of Special March F.H. East 24. Donation of SiCher (Special) 25. Sequentially sist conditions. 26. Please of Death (Special) 27. Sequentially sist conditions. 28. Part I conditions. 29. Please of Death (Special) 29. Death of Deposition March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 Approximate interval and address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 Approximate interval and address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 Approximate of Facility March F.H. East 1102 E. North Ave., Baltimore, Md. 21202 Approximate of Facility March F.H. East 1102 E. North Ave., Baltimore, Md. 21202 Approximate of Facility March F.H. East 1102 E. North Ave., Baltimore, Md. 21202 Approximate of Facility March F.H. East 1102 E. North Ave., Baltimore, Md. 21202 Approximate of Facility March F.H. East 1102 E. North Ave., Baltimore, Md. 21202 Approximate of Facility March F.H. East 1102 E. North Ave., Baltimore, Md. 21202 Approximate of Facility March F.H. East 1102 E. North Ave., Baltimore, Md. 21202 Approximate of Facility March F.H. East 1102 E. North Ave., Baltimore, Md. 21202 Approximate of Facility March F.H. East 1102 E. North Ave., Baltimore, Md. 21202 Approximate of Facility March F.H. East 1102 E. North Ave., Baltimore, Md. 21202 Approximate of Facility March F.H. East 1102 E. North Ave., Baltimore, Md. 21202 Approximate of Facility March F.H. East 1103 E. North Ave., Baltimore, Md. 21202 Approximate of Facility March F.H. East 1104 E. North Ave., Baltimore, Md. 21202 Approximate of Facility March F.H. East 1104 E. North Ave., Baltimore, Md. 21202 Approximate of Facility March F.H. East 1104 E. North Ave., Ba	d Mental marked c matic eve				ing Address (Street					
23a. Part I. Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest, interval Between Chest and Death shock, or host failure. List only one cause on each line. Immediate Cause (Final Between Chest and Death shock or host failure. List only one cause on each line. Immediate Cause (Final Between Chest and Death Seases or condition resulting in death). Due to (or as a consequence of): Due to (or as a consequ	lealth an om 27 is r her treur	Frank Campbell		nd 5.	15 N. Pati	terson Pa	rk Ave.	, Balti	more,	Md. 212
23a. Part 1. Einer the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased Between Chest and Death Shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): Due to	ment of H ent: If Ite ury or ot	1 Burial 2 ☐ Cremation 3	☐Removal from State	cemetery, cre	ematory or other place	ce)				
23a. Part. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest, interval Between cheek and beam shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): 1 Yes 2 No 3 2 2 2 2 2 2 2 2 2	Departi Import eny Inj once.	21. Signature of Funeral Service Lic	ensee	me_						21202
Females 1 1 1 1 1 1 1 1 1	/Medical Examiner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to a timediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consequence of):		ng, such as cardiac	or respiratory a	rrest,	6	Interval Between
29a. Certifier 29a. Certifier 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	ysicie ysicie ys bul	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ yes 2 □ No	d	of pregnancy 2 Fetal death 3		у				•
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	in res man in signed by and be detached by a detached by a detached by a by Phy		s contributing to death b	out not resulting in the	underlying cause giv	ven in Part I.	1			./
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be the discussion of the control of	physician: this certifical al director, To Be C	examiner? 1 ☐ Yes 2 ☐ No	1 Inpatie		SIL 3 DOA	ner: 4 Nursing H	ome 5 Res	idence 6 t		m Hospice
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	ter death. Director: After in by the funer.	1 Matural 5 Pending 2 Accident investigat 3 Suicide 6 Could no	ion		Wo M 1□	rk?	28f. Location /	Street and Num.		al Route Number,
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	Hospitel 24 hours a Funeral Call Rely filled i	(Check only 2 Medical Ex	aminer: On the basis o	f examination and/or i	ath occurred at the til	me, date and place opinion, death occur	and due to the	cause(s) and m date and place,	anner as s	stated. o the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. TSOMD Richart Hospine 838 N. Eutan St Baltimore MD 2 1201	within To the comple			4.00.					,	
I I WILLIAM I INTERPREDICTION OF THE PROPERTY	l	30. Name and address of person with ETCALID	no completed cause of c	death (Item 23a) (Type	Print)	+B-14	imre	MD =	1701	

State of Maryland / Department of Health and Mental Hygiene 006 28009 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** CISZEK JOHN Augus7 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year If Under 24 Hrs. 8. Day
Months Days Hours 447-Conton NENTHWEST 1105 BALTIMONE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Yrs. 212-76-0229 42 Director FEB 2. 1964 Maryland Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State ir than "natural", or Iteme 23e or 28e-f show The Medical Examinar must be inclified at 1 Yes 2 No Director Maryland Carrol1 Eldersburg 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1050 Caren Drive 21784 USA Funeral within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 21 No Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) filed withi Hygiene. Food Industry 12 <u>Salesman</u> and 2 should be file
and 0 Health and Mental Hyo.
The marken
Ty or other tree. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Marty Meise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce M. Ciszek (wife) 1050 Caren Drive Eldersburg. MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dapartment of Important: If any Injury or once. Sacred Heart of Jesus SEP 6, 2006 Baltimore, MD 22. Name and Address of Facility
Haight Funeral Home & Chapel
P.O. Box 195 Sykesville, MD 21784 (410-795-1400) 21. Signature of Funeral Service Licensee aund mol mald Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ENDSTAGE /Medical Due to (or as a consequence of) Examiner CERRHESI C ALCOHO Lie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? GASTROINTESTINA 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an paga 2 autopsy certificate 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one | Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No I Director: / d in by the f 2 Accident To within 24 hours.
To the Funerel Director.
To the Funerel Director. 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number KUD 19502 August 31 HUSDIAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CENGNAN RANDALISTAND, WARYLAND 13 CRIANDE 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State

Registrar

SEP 0 6 2006

Baltimore,

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Records,

of Vital

State of Maryland / Department of Health and Mental Hygien ? 28010 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Year **Physician** A^{M} 2006 3:21 Robert Samuel Cell September 4, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 5608 Jordan Road Bethesda If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Social Security Number 7 Age (In vrs. last birthday) **Funeral** Hours Months 1**X** M 2□ F 88 154-10-8452 February 1, 1918 Illinois Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2X No Bethesda Directo Maryland Montgomery 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 5608 Jordan Road 20816 United States Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: White Specify: If Yes, Give Year or Dates: WWII Completed by 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Banker Banking permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: If item 27 is marked other It any injury or other traumatic event, tha once. 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Cell Helen Magnuson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles L. Cell/son 301 S. Pioneer Drive, Long Grove, Iowa 52756 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition September ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9, Merrimac, Massachusetts Locust Grove Cemetery 2006 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Robert A. Fumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service Licens **Molification | Molification | Moli 7557 Wisconsin Avenue, Bethesda, Maryland 20814 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebrovascular Accident **Physician** /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Hyperlipidemia and Due to (or as a consequence of): attending physicien Box 68760 Physician/Medical as the t esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day detached for 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Records, P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 | Yes 2 | No 3 | Probably 4 Nunknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ormed? 2 🐼 No 1 ☐ Yes 2 ☐ No certificete 1 Yes Division of Vital Physician: ours after death. lerel Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: Hospital: 4 Nursing Home 5 \$\frac{\text{M}}{\text{Residence}}\$ Residence 6 □Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 FR/Outpatient 3□ DOA 2 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury Attending 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō within 24 hours a To the Funerel [To the Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D29353 September 5, 2006 guis MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George W. Graves, M.D. 5530 Wisconsin Avenue #925 Chevy Chase, Maryland 32. Registrar's Signa 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

SEP 0 6 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] [5 2801 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 1734 M entember Joseph Lance DeLeo, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bel Air, Maryland Upper Chesapeake Medical Center Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1₩ 2□F Days Hours Min 02/09/1936 70 Director Maryland 212-32-6846 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits rel', or iteme 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo MD Bel Air Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1812 Still Pond Way 21015 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White "naturel", tal Hygiene. d other than "nature event, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Maryland Department of Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineer Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surna Be Mental is marked ဥ Louise Serenella Joseph Lance DeLeo, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Depertment of Heelth a Important: if item 27 is eny injury or other tra 1812 Still Pond Way - Bel Air, Maryland 21015 <u> Antoinette M. DeLeo (wife)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【*Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 09/06/2006 Baltimore, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licenses ass 11750 Belair Road - Kingsville, Maryland 21087 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) **Physician** Hirhythmia 15mins /Medical Due to (or as a consequence of): Examiner ardiac fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Due to a consequence of): attending physicien a for use as the burial-Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Winknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has t irector, page 2 s 1 🗌 Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 > Inpatient 2 ER/Outpatient 3 DOA his 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

SFP 0 6 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jason Birnbaum - 500 Upper Chesapeake Drive - Bel Air, Maryland 21014

Date filed (Month, Day, Year) | 32 Begistrar's Signature

D0056296

9-4-2006

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 28012 006 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** September 2, 2006 8:20A Donald L. Daughters /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 7901 Charleston Court Bethesda If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) Sex 1 X M 2 ☐ F If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 031-22-2961 89 Vrs Dec. 4, 1916 Ohio Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Show Item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Execution mainted or califord at 1 ☐ Yes 2 No Montgomery Bethesda Maryland Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7901 Charleston Court 20817 United States death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: if Item 27 is marked other than "natural; or Item any Injury or other traumatic event, the Medical Event ADER. 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Federal Government/ Elementary/Secondary (0-12) College (1-4or 5+) General Management Private Business 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Roscoe Daughters Mary Early 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne F. Daughters/Wife 7901 Charleston Court, Bethesda, Maryland 20b. Place of Disposition (Name of Montgoiner) 20a. Method of Disposition 20c. Location - City or Town, State September 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State prium, Inc. 7, 2006

22 Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. 21. Signature of Funecal Service Lid M00803 Bethesda, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Alzheimers Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it is a cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner attending physician and Refor use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day signed by the at d be detached fo 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown Coronary Artery Disease Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Hypertension s certificate has b lirector, page 2 s autopsy performed? Yes 2 2 No ths Hospital or Attending Physician: after death.

Director: After this certific
In by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 \$\vec{M}\$ Residence 6 Other (Specify) 1 ☐ Yes 2 🖔 No ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours af To the Funeral D completely filled in 29a. Certifier 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and til 29c. License number 29d. Date signed (Month, Day, Year) 0 D26571 September 5, 2006 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10215 Fernwood Road, #401, Bethesda, Maryland Irving Mizus, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar Coarles SFP 0 6 2006

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2006 28013 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 40 200 T: /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rehab 13 ac nwood and 1 1+1 M 2 VL If Under 24 Hrs. Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Fordign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 M M 2□ F Director 62 63 Oct 26, Usuel Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10h Counts in than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at 1√2Yes 2□No MD Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 501 W. Franklin Street 21201 USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give unk filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: black <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 is marked other the any injury or other treumatic event, IIIA 2006. unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk unk ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 501 W. Franklin Street Baltimore, MD 21201 Ravenwood Nursing Center 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 Donation SMOther (Specify) in state 21. Signature of Funeral Prvice Licensee Ronald S. W. 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MĎ 21201 Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a on each line. Enter the disease or complications or heart failure. List only one cause Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law raquiras that the death cartificate be executed Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) has basn signed by the age 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificata ictula healed 2 No you Chapleural To the Hospitel or Attending Physicien: 26. Place of Death | Check only one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☐ No ပ 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending To the mospies.

within 24 hours after death.

To the Funeral Diractor: Att 2 □ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S, DANG M. D. 101 ST, HELELAAVE BALTIMORE ATPAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 6 2006

State of Maryland / Department of Health and Mental Hygiene? $\cap \cap \subset$

			For State Registrar	State of Man	yland	l / Depa <i>Cei</i>	artment of I	Health Death	and M		ene 2 (006	28014
			1. Decedent's Name (First, Middle, Last)							2. Date of Death Month	Day	Yeas	3. Time of Death
	Physici /Medic		JOSEPHINE	EPSTEIN	1					SEPTEMBER	02 2	1006	2.15 A M
	Examin		4a. Fecility Name (If not institution, give s			-	4b. City, Town,		of Death		4c. Coun	ty of Death	
			NORTHWEST HOSPITA				RANDA				BAL	TIMOR	
	Funeral		5. Social Security Number 6. Sex 219-18-9784 1□	7. Age (//	n yrs. la 82	st birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birth	924	9. Birth	place (State or Foreign Intry) MD
	Director		Usual Residence of Decedent										
	ytand		10a. State 10b. County	10	c. City,	Town or Lo	cation						10d. Inside City Limits
	Maried	ţō	MD BALTIMO	ORE		RANI	DALLSTOW	N					1 ☐ Yes 2 🔀 No
	or 28	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen o	What Cou	•
	within 72 hours after deeth with the Maryland ene. Then "natural", or iteme 23a or 28a-f ehow he Medical Examiner must be netified a	ral	4210 HOLBROOK ROA					211					USA
	er de	Funeral	Tr. Maria Grana	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 X No	er in U.S	13.	Was Decedent of f Yes, specify Cul	Hispanic O ban, Mexica	rigin? (Spe an, Puerto	ecify Yes or No- Rican, etc.)		ace - Amer ack, White	ican Indian, , etc.
99	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 LYes 2 No If Yes, Give Year or Dates:			1□Yes 2XX No	Specify	<i>y</i> :		Spec	ity:	WHITE
Ş	tural E	ed	15. Decedent's Educ			16a. Deced	dent's Usual Occu	pation			6b. Kind of	Business/I	ndustry
75	nin 7	plet	(Specify only highest grade Elementary/Secondary (0-12)	Cotlege (1-4or 5+)		life.	kind of work done DO NOT use retir	ed) during mo	st of worki	ng			
21	d with	Completed	Elementary/obcorreary (o 12)	001090 (1 401 37)	4	HOM	EMAKER				OWN H	OME	
D	at Hygir d other	Be (17. Father's Name (First, Middle, Last)			715	01 50			(First, Middle, N	faiden Suma	ime)	LEVIE
<u>yla</u>	2 should be to and Mental He marked of raumatic eve	၉	JOSEPH	_			RLER		ETSY				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Dependent of Heatil and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified a page.	7,1	19a. Informant's Name/Relationship (Ty) MARCIA MEYER / DA							al Route Number. RANDALLS			
	l and Health om 27 ther ti	- 3	20a. Method of Disposition		20h Pla		sition (Name of	K NOA			Oc. Location		
Baltimore,	Pages nent of h int: if ite iry or of		1 X Burial 2 □ Cremation 3 □ R	emoval from State	CO	metery, crer	natory or other pl						
턀	it. Partmer		4 □Donation 5 □ Other (Specify) 21. Signature of Puneral Service Service		SALI		HEBREW			/2006			OWN, MD
Ba	permit. Depertrimports ony injustra		Jan J						. 30	L LEVINS			
			23a. Part 1. Epter the disease, or compli	cations that caused the	e death.							11-1-1	Approximate
	Physician		shock, or heart failure. List only on Immediate Cause (Final	0	. 0	(.0 =		•					Interval Between Onset and Death
}	/Medical		disease or condition resulting in death)	Due to (or as a c			WURR	130	CID	ENT			
н	Examiner		O			D	EMIEM	TIA					
	p =W	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a c	onseque	ence of):							
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last										
8760,	death certificate be executed elitending physicien and ad for use as the burial-transit	E		Due to (or as a c	onsador	enceron).							
687	phys s the	dlcal		-									
Box (certif nding use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of							23d. D	ate of delin	very
ă	that the death cer ad by the ettendir detached for use	Cla	in the past 12 months? 1 Yes 2 No	1 Live birth 2 [4 Pregnant at tin			Ectopic pregnan Other (specify)	cy				fonth	Day Year
0	it the d by the tached	hys	9 Unknown	9□ Unknown									
S, D	The law requires that the see has been signed by th page 2 should be detache	by P	Part II. Other significent conditions con	tributing to death but r	not resul	lting in the u	nderlying cause g	iven in Part	ł I.	23e. Did tob	acco use co	ntribute to	the cause of death?
ğ	w require been si should b	be d								1 🗆 Ye	s 2 No	3 🗌 Pro	bably 4 Unknown
of Vital Record	e lawr has be je 2 sh	Completed								24a. Was ar	/	. Were aut	opsy findings available omptetion of cause of
Œ		5								perform 1 ☐ Yes 2	ned? ⊠No	death? 1 ☐ Yes	2 X No
/ita	iclan: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Ioonital, EGE					ce of Death	(Check only one	9)		
of	Physiclan: this certific ral director.	ို	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury		P/Outpatier 28b. Time of	IL SEL DOA			me 5 Reside			ify)
_	a fe	9	1 X Natural 5 ☐ Pending	(Month, Day Y	ear)	Injury	W	ork? ⊡Yes 2.[200. Describe no	w injury occi	illed	
Division	Attending in death. ector: After by the funer	fica	3 Suicide 6 Could not be	28e. Ptace of Injury	- At hor	ne, farm, str				28f. Location (St	eet and Nur	nber or Rui	ral Route Number,
⋛	effer offer d in b	Certification:	4 Homicide determined	building, etc. (Specify))	,,,,			City or Town	, State)		
	To the Hospital or Attending Physician: within 24 hours eller death. To the Funeral Director: After this certific completely filled in by the funeral director.			sician: To the best of r									
	he Hi in 24 he Fu	edical	(Check only 2/ Medical Examile one)	ner: On the basis of ex and manner state	d.	on and/or in							\
	With To 1	Σ	29b. Signature and title of certifier	meht	· W	10		nse number		25	d. Date sign	ned (Month	Day Year)
•	0		- Kannon	1. (- 1 ^y	1.0		4141			ELLEWI	nek c	12,2006.
	1		30. Name and address of person who co	•	th (Item			NDEP		MEHTA		^	
			31. Date filed (Month, Day, Year)	Registrar's	Signati		KAMOAU	STO	M	MO	2113	5.	
	Sta Registi		SEP 0 6 2006	Same	K	S.	Bi						

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i> a	artment of He rtificate of D			iene 19. No 2006	28015
	Physici	an	Decedent's Name (First, Middle, La	ist)				2. Date of Death	Day Year	3. Time of Death
	/Medic Examin		Mary Epps 4a. Facility Name (If not institution, gir	ve street and number)		4b. City, Town, or L	ocation of Death	august	4c. County of Dea	
			Maryland Gene		Hal	Battim	oro Ci-	ty		
	Funeral Director			Sex 7. Alge 1 □ M 2 ∏ F	e (In yrs. last birthday) 85 Yrs.	Months Days	Hours Min.	B) Date of Birth (Month, Day, July 4,	Year) 9. Bit C	rthplace (State or Foreign ountry) unk
	ס		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryla fed at	jo	MD 100. Godiny		Baltimore	Cation				1 Yes 2 □ No
	or 28a	lrec	10e. Street and Number			10f. Zip Code		10	og. Citizen of What C	ountry?
	ath will	raiD	4017 Liberty Hei				1207		USA	
•	fter de	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 Yes 2 N	lo	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Sp Mexican, Puerto	Rican, etc.)	14. Race - Am Black, Wh	
ğ	within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f show Te Moulcal Exacitrar must be notified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 21 No	Specify:		Specify:	olack
	in 72 h "natu	Completed	15. Decedent's E (Specify only highest gi	rade completed)	(Give	dent's Usual Occupati kind of work done du DO NOT use retired)			16b. Kind of Business	s/Industry unk
212	d with giene.	Comp	Elementary/Secondary (0-12) unk	College (1-4or 5 unk	+)					
and	nta! Hy ad oth ad oth	Be	17. Father's Name (First, Middle, Las	t)		unk 1	8. Mother's Nam	e (First, Middle, M	faiden Sumame)	unk
Maryland 21215-0036	ges 1 end 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. 1 of Health and Mental Hygiene. 1 of Health and Mental Hygiene. 1 or other traumatic avant, the Medical Examinat matches notified at	2	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street an	nd Number or Rur	ral Route Number,	City or Town, State,	Zip Code)
	# 4 2 G		Maryland General	L Hospital		Linden Ave				
Baltimore,	permit. Pages 1 en Dapartment of Heal Important: If Itam 2 any injury or other 2005.		20a. Method of Disposition 1 Burial 2 Cremation 3	☐Removal from State	1	osition (Name of matory or other place)		Date 2	20c. Location - City o	r Town, State
	permit. Pa Dapartme important any injury once.		4 □Donation 5 MOther (Spec 21. Signatur of Funeral Sep ce Lice Pom 1 d S	m in state	/ 2	2. Name and Address	of Facility			
<u>m</u>	Par in a	1. 75	my	11111	18	tate Anato altimore,	MD 2120	1		· · · · · · · · · · · · · · · · · · ·
			23a. Part 1. Enter the disease, of cor shock, or heart failure. List only Immediate Cause (Final	nplications that caused one cause on each lin						Approximate Interval Between Onset and Death
}	Physician /Medical		disease or condition resulting in death)	a. Hther Due to (or as	a consequence of):	itic (a	callo vasa	eular 1)isease	
	Examiner		Sequentially list conditions,	. Hyper	Ttensio	1				
	per list	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as	a consequence of):					
o Î	execu en and rial-tra		that initiated events resulting in death) Last	Due to (or as	a consequence of):					
8760	death certificate be executed e attending physicien and od for use as the burial-transit	dical		d						
9	leath certific attending p	/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	elivery
Box	death	Completed by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)			Month	Day Year
о. О	The law requires that the de ste has been signed by the c page 2 should be detached	Phy	9 ☐ Unknown Part II. Other significant conditions		ut not resulting in the u	inderlying cause given	in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ds,	n signe	d by	Dia betes 1	nellitus	<u> </u>			1 □ Ye	s 2 No 3 F	Probably 4 Onknown
Hecords,		piet						24a. Was ar	24b. Were a	autopsy findings available completion of cause of
<u> </u>	Physician: The la r this certificete has ral director, page 2							perform 1 ☐ Yes 2	ned? death? □ I ☐ Ye	s 2□ No
=	/siciar s certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 (Hinpatie	nt 2 ☐ ER/Outpatie	Othor		th <i>Check only one</i> ome 5 ☐ Reside	nce 6 ☐Other (Sp	ecify)
Division of Vital	or Attanding Physician: after death. Director: After this certifice in by the funeral director, i		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 28b. Time o	f 28c. Injury a	at		w injury occurred	
Sio	uttendi death. ctor: A r the fu	cati	2 Accident investigation 3 Suicide 6 Could not	be Ose Bless of Inju	ury - Al home, farm, st		es 2 No	28f Location (Str.	reet and Number or F	Rural Route Number
2	safter safter ni Dire ed in by	Certification:	4 Homicide determined	building, etc	c. (Specify)	root, raciory, onica		City or Town	, State)	
	To the Hospital or Attending Ph within 24 hours after death To the Funeral Director: After th completely filled in by the funeral	Medicai	29a. Certifier 1	hysician: To the best of miner: On the basis of and manner sta	examination and/or in	th occurred at the time evestigation, in my opin	, date and place, nion, death occur	and due to the ca red at the time, da	use(s) and manner a ate and place, and du	is stated. ie to the cause(s)
	To the To the comp	Ž	29b. Signature and title of certifier.	lali.	MAD	29c. License	number	29	9d. Date signed (Mor	
			30 Name and address of person who	completed cause of de	eath (Item 23a) (Tupe	Print)	1307		nugusta	6,2006
_			Maria Borada	tcheva	m.D %	Maryk	and Ge	eneral	Hospita	1
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 6 20	32: Registra	ar's Signature	sole				
	J		Tulf House of	4	-					

State of Maryland / Department of Health and Mental Hygiene 2006 28016 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** Jeffrey Fogel Sept. 06 10:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7509 Saffron Crt. Hanover <u> Anne Arundel</u> If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day,)
July 18, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1☐M 2☐F 7. Age (In yrs. last birthday) **Funeral** Year) 56 July 1950 P.A. Director 202-40-3589 Usual Residence of Decedent deeth with the Maryland 10a. State 10c. City, Town or Location r than "naturel", or iteme 23a or 28a-f show Ite Medical Examiner must be notified at 10b. County 10d. Inside City Limits 1 XYes 2 No Anne Arundel Hanover Direct 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 1011 Rectory Ln. 21211 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc. be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No ð 3 Widowed 4 Divorced white white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "na eny injury or other traumatic event, II a Madic 2008. Elementary/Secondary (0-12) College (1-4or 5+) Artist <u>Independent</u> Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Albert Fogel <u>Beatrice Hilk</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacey Gear - Wife 1011 Rectory Ln. Baltimore, MD 21211 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Sep. 5, 06 Baltimore, MD 21. Signature of Funeral Service Licens ²² Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hoblastoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physicien for use as the buria Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f □Yes 2□No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy 200 No certificate 1 Yes 2 1 No Attending Physician: Director: After this certific in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5 filled 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 033220 MU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Betsy A. Fay, MD 3730 Falls Road Baltimore, Maryland 21211 31. Date filed (Month, Day, Year) 22. Registrar's Signature State SEP 0 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygien 2006

			1 - For State Ragistrar Cer	tificate of Death	Reg. t	
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Oay Year 3. Time of Death
	/Medic	al	Ronald Stewart Frick 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		r 3, 2006 6:30 P M
	Examin	er	3070 Daisy Lane	White Hall		Harford
ė	Funeral Director	V V	5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 1 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 04-28-19:	9. Birthplace (State or Foreign Country) Maryland
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc			10d. Inside City Limits
	e-feh	ctor	Maryland Harford White H	Hall		1 Tyes 2 No
	a with the	Funeral Director	10e. Street and Number 3070 Daisy Lane	10f. Zip Code 21161	10g.	Citizen of What Country?
	r death	iner	11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Was Decedent of Hispanic Origin? (Sperf Yes, specify Cuban, Mexican, Puerto F	crfy Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
2-0030	be filed within 72 hours after death with the Maryland stal Hygiene. Ided other than "natural", or Iteme 23e or 28e-fehow other than "satisfied Examinar must be notified at event, the Madical Examinar must be notified at	by	t ⊓ Never Married 2 □ Married 1 □ Yes 2 □ No 1 ¥ 2 ⊠ −	I ☐ Yes 2 🛣 No Specify:		Specify: White
ה ה ה	hin 72 h s. In "natu Medical	Completed	(Specify only highest grade completed) (Give	lent's Usual Occupation kind of work done during most of workin DO NOT use retired)	g	. Kind of Business/Industry
V	filed with Hygiene ther the	Com	12 Store	Manager		Grocery Store
yiand	d be fill ental H sed ott	To Be	17. Father's Name (First, Middle, Last) Herbert J. Miller		(First, Middle, Maid N. Nalpin	en Sumame)
ar Z	2 should by and Menta le marked eumatic ev	F	19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	ng Address (Street and Number or Rura	l Route Number, Cit	y or Town, State, Zip Code)
, mar	ges 1 and 2 should t of Health and Mer If item 27 le marke or other treumatic					Maryland 21161
Jore	ages 1 of H or of H or oth		1 X Burial 2 Cremation 3 Hemoval from State Daylough	natory or other place)		Location - City or Town, State rkville, Maryland
Бащтог	permit. Pages 1 Depertment of h importent: If ite eny injury or ot		21. Signature of Funeral Service Licensee Charles Minor 22	. Name and Address of Facility	5305	Harford Road
ñ	Depe impo eny io		Charles Mener			more, Maryland 21214
Jan.	Physician /Medical Examiner			of the Prostate		Approximate Interval Between Onset and Death
./	be sit	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
v	icate be executed physician and s the burial-transit	Examiner	that initiated events c			
8/PU	ate be hysicia the bur	lical	d			
O. BOX 6	ath certif attending for use as	Physician/Medical		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
JS, T	w requires that the de been signed by the s should be detached	by	Part II. Dther significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		co use contribute to the cause of death?
cord	w requ been should	Completed			24a. Was an	24b. Were autopsy findings available
Ī	The	omo			autopsy performed	prior to completion of cause of death?
VITal	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	26. Place of Death	1	
ō	Phys	: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien 27. Manner of Death (Month, Day Year) Injury (Month, Day Year) Injury		ne 5 Residence 28d. Describe how in	
LO I	Attending r death. sctor: After by the fune	ation:	2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
DIVISION	or Atta after de Directo in by th	Certificati	3 ☐ Surcide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospitel or Attandi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one) 1 Cartifying Physician: To the bast of my knowledge, deatly one) 1 Medical Examinar: On the basis of examination and/or in and manner stated.			
	To the within To the	Me	29b. Signalure and title of certifier	29c. License number	29d.	Date signed (Month, Dey, Year)
			12/000	D42979	2	eptember 5, 2006
	Q		30. Name and address of person who completed cause of death (Item 23a) (Type, Michael A. Carcluci MD 401 North 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 0 6 2006	Print) Romedury Rell	in de Mi	121031
No.	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Mes	7776	729
	Registr	ar	SEP 0 6 ZUUD	Ac en		

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 3. Time of DeathA 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 7:50 M Physician Leah E. Ford are /Medical 4b. City, Town, or Location of Death Randallstown 4c. County of Death
Baltimore 4a. Fecility Name (If not institution, give street and number) Examiner Chapel Hill Nursing Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Manch Days | Hours | Min. | Manch Days | Year | 911 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2 F Maryland 95 Yrs. 220-30-3396 Director Usual Residence of Decedent filed within 72 hours atter death with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at Woodstock Baltimore Maryland 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21163 United States 10610 St. Paul Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 25 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Marned White 1 ☐ Yes 2 No Specify: ፩ 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then " Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be lik Department of Health and Mental Hy Important: if Item 27 is marked oth eny lijury or other treumetic event 2008. 17. Father's Name (First, Middle, Last) Be Clara Rittase Grover C. Marr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12011 Tralee Road Unit #502 Timonium, MD 21093 19a. Informant's Name/Relationship (Type, Print) Wallace H. Ford, Jr. grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ACremation 3 Removal from State South Carroll Crematory Sept. 3, 2006 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Burrier-Oueen Funeral Home & Crematory, PA 1212 W. Old Liberty Road Winfield, MD 21784 aun 23a. P n1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hoc, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dis act or condition resulting in death) **Physician** Metastatic brain weeks /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to to, as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of): ettending physicien for use as the buria Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificete hes autopsy performed? 1 Yes 2 →No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this After the 28c. Injury at Work? 27. Manner of Death 1 ☑Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ş 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) Type, Print)

31. Date filed (Month, Day, Year)

SEP 0 6 2006

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

7220 Park Helphy

32. Registrar's Signature

			Registrar		Ce	rtificate of	Death		Reg. No	2000	20015
	Physicia /Medic		Decedent's Name (First, Middle, Las BEULAH FOGLE	it)				2. Date of Month	Death Da		3. Time of Death
	Examin	er	4a. Fecility Name (If not institution, give UNION MEMORIA) 5. Social Security Number 6. S	L HOSPITA		_	IMORE			N/A	n nplace (State or Foreign
	Funeral Director				88 Yrs.	Months Days	Hours Mi	n. (Month	Day, Year, -1918) Cou	RYLAND
Maryland	f show	tor	10a. State 10b. County MD • N/A		10c. City, Town or Le						10d. Inside City Limits ↑ Yes 2 □ No
di d	a or 28e Lbe nutii	Director	10e. Street and Number	DD.		10f. Zip Code	E		10g. Ci	itizen of What Co	untry?
5-0036	to their and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-f shoy or other treumatic event. It a Medical Examinar must be notified at	by Funeral	3200 DORCHESTER 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force: 1 Yes 25 If Yes, Give Year or Dates	- No	Was Decedent of H If Yes, specify Cub		(Specify Yes of erto Rican, etc.	r No-	USA 14. Race - Ameri Black, White	, etc.
21215-0036	e. han "natural Medical E.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation	16a. Dece (Give life.	dent's Usual Occup s kind of work done DO NOT use retire	during most of w	rorking	16b. h	Kind of Business/I	ndustry
	io marked other than eumatic event, I'm Mi	To Be Con	-12- 17. Father's Name (First, Middle, Last) CHARLES FOGLE	_4_		CEACHER	18. Mother's N	ame (First, Mic	ddle, Maide	LTIMORE (n Sumame)	CITY
, Maryland	ulth and Me 27 ie mark r treumati	F	19a. Informant's Name/Relationship (CHARLENE GRIFFI			ing Address (Street	and Number or	Rural Route No	ım <i>ber, Cit</i> y		
Baltimore,	popularity of the substitution of the substitu		20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from Sta	20b. Place of Disp cemetery, cre	osition (Name of matory or other pla		Date		ocation · City or	
Baltil	Department of Importent: if it any injury or concess.		21. Signature of Euroral Service Licer		N D. HIBNER	2. Name and Addre	ess of Facility P	HILLIP	S FUNI	ERAL HOM	
	hysician /Medical		23a. Part1. Efter the disease, or comshock, in heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Conq	ed the death. Do not en i line.	Heart	-	lac or respirato			Approximate Interval Between Onset and Death
	ohysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	as a consequence of):	ase				= 11	years
ords, P.O. Box 58/60, 78	ed by the attending photograph detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 12 No 9 ☐ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregnanc □ Other (specify) _	y			23d. Date of deli Month	very Day Year
rds, P	n signed build be deta	d by Pr	Part II. Other significant conditions of	contributing to death	n but not resulting in the	underlying cause gr	ven in Part I.				the cause of death?
Rec	S S	complete						- 8	Was an autopsy performed?	prior to death?	topsy findings available completion of cause of 2 \sum No
on of Vital	After this certificate ha funeral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 W No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio			of 28c. Inju	her: 4 🗆 Nursing		Residence	6 Other (Specury occurred	sify)
Division	within 24 hours after death. To the Funerei Director: After completely filled in by the funer.	Certification;	3 Suicide 6 Could not be determined		Injury - At home, farm, s etc. (Specify)	treet, factory, office		28f. Locati City of	on (Street a r Town, Sta	and Number or Ru te)	ral Route Number,
	in 24 hour	edicai	(Check only 2 Medical Examone)	nysician: To the be niner: On the basis and manner	st of my knowledge, dea s of examination and/or i stated.	nvestigation, in my	opinion, death or	ice, and due to occurred at the ti	me, date ar	nd place, and due	to the cause(s)
H	1	M	29b. Signature and title of certifier	napakh		29c. Licen	o 611	87	29d. D	ate signed (Mont)	n, Day, Year)
	b Sta	ite	30. Name and address of person who Sound Gav 31. Date filed (Month, Day, Year)	napafl	of death (Item 23a) (Type MD strar's Signature	Print) Union	Memor	ial H	bestit	al Ba	ltimore, Mi

			For State Of M State Registrar 1. Decedent's Name (First, Middle, Last)	aryland / Depa	rtificate of D	eath		Reg. No.	28020
	Physicia /Medic	ın ,	Harry A. Gail, Jr.			S	Month eptember	er 1, 2006	7:45 PM M
	Examin	er	4a. Facility Name (If not institution, give street and number,	1	4b. City, Town, or L			4c. County of Deal	
			Manor Care Roland Park 5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)		1timore If Under 24 Hrs.	8 Date of Birth	Baltimore	
	Funeral Director		5. Social Security Number 6. Sex 1 1	83 Yrs.	Months Days	Hours Min.	8. Date of Birtl (Month, Day 01/07/1	, Year) Co .923 MD	thplace (State or Foreign buntry)
	Maryiand -f show	ō	10a. State 10b. County D Baltimore City	10c. City, Town or Lo	ocation				10d. Inside City Limits 1 X Yes 2 □ No
	with the	Director	10e. Street and Number 3704 Copley Road	1	10f. Zip Code 21215			10g. Citizen of What Co	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene, It marked other then "naturel; or items 23e or 28a-f show other treumatic event, it e Macrical Examinet must be inclined and	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deceden Armed Forces 1 Never Married 2 Married 15. Was Deceden Armed Forces 1 Never Married 2 Married 16. Yes 2 Francische Francisch	No	Was Decedent of His If Yes, specify Cuban, 1 ☐ Yes 2 No	panic Origin? (Spec , Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	te, etc.
21215-0036	within 72 hou ene. then "nature ne Monical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	5+) (Give	edent's Usual Occupat e kind of work done du DO NOT use retired)	iring most of workin	1	16b. Kind of Business Health Care	/Industry
	12 should be filed within " n and Mental Hygiene." 7 is marked other then " ireumatic event, Ire Max	Be	17. Father's Name (First, Middle, Last) Harry A. Gail, Sr.	Psych		18. Mother's Name Edith Joh	(First, Middle,	Maiden Sumame)	
Maryland	id 2 shoul th and Me 27 is mark treumati	P.	19a. Informant's Name/Relationship (Type, Print) Allenette Valentine/Daughter		ing Address (Street ar			or, City or Town, State, 21215	Zip Code)
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tree		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	9	osition (Name of ematory or other place, se Cremator		ate ep 5	20c. Location - City or Beltsville,	
Balti	permit. F Departm Importar any injur		21. Signature of Funeral Service Licensee	Ci	2. Name and Address	of Facility d Funeral	Alterna ive Ba	tives ltımore, Maı	rvland
	Physician /Medical		23a. Part 1. Elter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)						Approximate Interval Between Onset and Death
760, <	Examiner	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	s a consequence of): Abelt s a consequence of):	nleatu	2			
P.O. Box 687	death certifica e attending ph id for use as th	by Physician/Medica		e of pregnancy 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	olivery Day Year
	requires that the een signed by th hould be detache	d by Ph	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause give	n in Part I.	23e. Did t	obacco use contribute t Yes 2□No 3□P	o the cause of death?
Division of Vital Records,	The lar ate has page 2	Completed					24a. Was autop perfo 1 🗌 Yes	prior to death?	utopsy findings available completion of cause of s
/ita	ertific ector,	Be (25. Was case referred to medical examiner?		Other	26. Place of Death			
on of \	ing Phy I. After this tuneral d	은	1 Yes 2 No Hospital: 1 Inpa 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation (Month, L	jury 2 □ ER/Outpatie jury 28b. Time lnjury	of 28c Injury Work	at 2		dence 6 Other (Spe how injury occurred	əcify)
Divis	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 28e. Place of I	njury - At home, farm, s etc. <i>(Specify)</i>	treet, factory, office	:	28f. Location (City or Tox	Street and Number or F wn, State)	Rural Route Number,
	ne Hospil n 24 hour ne Funere	ledical (29a. Certifier (Check only one) 1 Certifying Physician: To the besis and manner	of examination and/or i	ath occurred at the time investigation, in my op	e, date and place, a inion, death occurr	ed at the time,	date and place, and du	e to the cause(s)
)	To the To the Comp	M	29b. Signature and title of certifier	MD	29c. License	31464		29d. Date signed (Mon	6
	541		30. Name and address of person who completed cause of SHOA113 A HASHMIMP	death (Item 23a) (Type	a, Print) EU 7AW S	T Snite.	300 [BALTIMON	MD 2120
	Sta Regist		31. Date filed (Month, Day, Year) SEP 0 6 2006	strar's Signature	pare.				

State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006

28021 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPT. ANNA CATHERINE GALLIPPI Physician 2006 5:28AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street end number) Examiner Baltimore Parkville Oak Crest Village 9. Birthplace (State or Foreign Country) Mary Land If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 16,1916 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□ M ŽŽF 90 215-07-3074 Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County nemit. Pages 1 and 2 should be filed within 72 hours after death with the maryan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23e or 28e-1 show any Injury or other treumatic event, I'm Medical Examinst must be nothing at Baltimore County 1 ☐ Yes 2 No Baltimore Maryland Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 21234 USA 8810 Walther Blvd. Apt. 1220 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes ŽŽ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Maryland 21215-0020 \$ XX Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 9 yrs. Self~Employed Salesperson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Margaret A. Miller Joseph A. Schafer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 938 Delray Drive Forest Hill, Md. 21050 Richard Gallippi (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9~6~06 Baltimore, Md. St. Jos. Ch. Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, md. 21236 Approximate Interval Between Onset end Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical d stage thinkney dispused

Due to (or as a consequence of): Examiner Physician/Medical Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and Knompletely filled in by the funeral director, page 2 should be deteched for use as the bunel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ briknown Dichetes Completed by Division of Vital Records, 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier September 5 2006 mone 058646 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) walther Boulevard Parkville, MO21234 mnc 5800 32. Mgistrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 6 2006 Registrar

			1 - For Amend iter	#1,pe	State of	Maryla 10/3/0	nd / Depa	artment of H	lealth ar D <i>eath</i>	nd Mental H	ygiene Reg. No.	2006	28022
			1. Decedent's Name (First, M	iddle, Las	st) Dorot	hy Marg	reta Gree		-	2. Date of D	eath		3. Time of Death
	Physici		Boroth V	44	ir gare	10	(> F E	en_		Month	Day Day	Year 2, 2006	2:05 A ^M
	/Medio Examin		4a. Facility Name (If not instit					4b. City, Town, or	Location of I			County of Death	
			Rock Spring V	illad	ge			Forest H	ill		Н	arford	
	Funeral		5. Social Security Number	6. S	ex □M 2√⊋F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, L	Day, Year)	Col	nplace (State or Foreign intry)
-	Director		214-03-6961 Usual Residence of Deceden		X-	92	YTS.			Apr.	23, 1	914 Mary	zland
	land ow		10a. State 10b. Con			10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
	Mary Ff 8h	tor	Maryland Har	ford		Fo	orest H	ill					1 ☐ Yes 2 ☑ No
	r 28s	Director	10e. Street and Number					10f. Zip Code			10g. Citi	izen of What Co	untry?
	th with	aiD	1 Colgate Dri	ve.				21050			US	A	
	ams ams	Funeral	11. Marital Status		12. Was Dece	dent Ever in	U.S. 13.	Was Decedent of H	ispanic Origir In, Mexican, F	n? (Specify Yes or N		14. Race - Amer Black, White	
36	72 hours after death with the Maryland natural", or Itams 23a or 28a-f show Acal Examir not mat be molified at		1 Never Married 2		1 ∐Yes If Yes, Give	2 X No		1 ☐ Yes 2 ☐ XNo	Specify:	,		Specify:	, 500
21215-0036	hours tural',	ed by	3 XWidowed 4 Divo	dent's Ed	Year or Da	ites:	16a Daga	dent's Usual Occup	ation		16h V	Whj	
15	in 72	Completed	(Specify only hi	ghest gra	de completed)		(Give	kind of work done of DO NOT use retired	during most o	of working	100. 6	ing or pasinessy	ndustry
12	with iene. r thar	mo	Elementary/Secondary (0-	2)	College (1-	-4or 5+)	C1.	aims Exam	iner		Sta	te	
	e filed Hyg otha	BeC	17. Father's Name (First, Mic	dle, Last))					s Name (First, Midd			
<u>la</u>	uld be Aenta rked tlc ev		Willard LeRoy	Tucl	ker				Cather	rine Caro	line 2	Andrews	
Maryland	and h		19a. Informant's Name/Relat	ionship (Type, Print)					or Rural Route Nurr	•		
	and and malth m 27		Carolyn Morto	n/ Da	aughter		_		Rd.,	Newark, I			
ore	ges 1 1 of H If itan		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremat	ion 3 🗆	Removal from S		Place of Dispo cemetery, crei	sition (Name of matory or other plac	:e)	Date	20c. Lo	ocation - City or	Town, State
Ë	Pag tment tant: jury		`4 ☐Donation 5 ☐ Othe	r (Specif	y)	Ce		9-7-06		st Hill	Maryland		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examination instituted at once.		21. Signature of Funeral Ser	rice Licer	Luck		ss of Facility Ineral Sbury F	Home, P.A Rd., Abing	A. gdon,	Marylar	nd 21009		
			23a. Part1. Enter the diseas shock, or heart failure.	e, or com List only	plications that ca	aused the dea ach line.	ath. Do not en	ter the mode of dyin	g, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	1000	a Ct	+1=							Onset and Death
	/Medical Examiner		resulting in death)		Due to (or as a conse	equence of):						
Н		-	Sequentially list conditions, if any, leading to immediate		b. Due to (or as a conse	equence of):					-	
۸	ted nsit	nlne	Cause (Disease or injury	<	0	00	()						
P ·	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	-1	C. Due to (or as a conse	quence of):						
8760,	e be sicia e bur	dicai		·	d.								
9		a a											
Box	death certitii e attending p id tor use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnan		23c. If yes, outo	come of pregi		JEctopic pregnancy	,			23d. Date of deli	,
	deat	sicia	in the past 12 months? 1 ☐ Yes 2 2 No			ant at time of		Other (specify)				Month	Day Year
P.0	w requires that the deben signed by the should be detached	Phys	9 Unknown										
	es the	by	Part II. Other significant cor	ditions o	contributing to de	ath but not re	sulting in the u	nderlying cause giv	en in Part I.				the cause of death?
ord	een s	ted							<u>.</u>		Yes 2	□N0 3□PR	bbably 4 Unknown
Records,	alaw nasb e2st	Completed								24a. Wa	opsy	prior to c	topsy findings available ompletion of cause of
E H	: The law cate has b page 2 s	Cor								1 Tes	formed? 2 No	death?	X No
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to me examiner?	dical	Hospital:			oth Oth	0.00	of Death (Check only			
of	ding Physician: n. Atter this certific	. To	1 Yes No 27. Manner of Death		28a. Date o		ER/Outpatier	IL 3 DOA	4 M Nurs	ing Home 5 Re			ify)
5	ta in	tion	1 X Natural 5 □ Pe	nding estigation	(Monti	h, Day Year)	Injury	Wor	k? Yes 2⊟No		3 11044 111101	y occurred	
Division	Attanding r death. actor: Atter	fica	3 ☐ Suicide 6 ☐ Co	uld not b	e Zeo Placo	of Injury - At	home, farm, st	reet, factory, office			(Street an	nd Number or Ru	ral Route Number,
Div	atter atter Dira	Certification;	4 Homicide de	remined	buildir	ng, etc. (Spec	cify)	,,		City or 7	own, State)	
	To the Hospital or Attandi within 24 hours after death. To tha Funeral Diractor: A completely tilled in by the fu	edical C				isis of examir				place, and due to the occurred at the time			
	ro the	Me	29b. Signature and title of ce	rtifier		10		29c. Licens	e number		29d. Dat	te signed (Month	, Day, Year)
	. 21 0		1 Feel	14	M	100		D28	489		9	12106	
	10		30. Name and address of pe	son who	completed caus		em 23a) (Type,	Print) Bel	Au	max	210	111	
	Sta	te_	31. Date filed (Month, Day,)				natura						
	Regist		SEP 0		06	و معدد	K A	who -					
					6"		4						

		1_ State	epartment of Health and Modernificate of Death	lental Hygien	2006 28023
		1. Decedent's Name (First, Middle, Last)	ACTUMORIC OF BOART	2. Date of Death	3. Time of Death
Physicia		Almeda Pennington Gross		September	1, 2006 10:55AM
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
		Hart Heritage Assisted Livin	g Street	I	Harford
Funeral Director		5. Social Security Number 6. Sex 1. Age (In yrs. last birth 1. M 2 ■ F 83	Months Davs Hours Min.	8. Date of Birth (Month, Day, Year Oct. 20,	9. Birthplace (State or Foreign Country) 1922 Maryland
and **		Usual Residence of Decedent 10a, State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
Manyla f sho	ō	Maryland Harford Forest	u-11		1 ☐ Yes 2X No
the the round	rect	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
3a of	Funeral Director	2002 Brandy Drive	21050	US	SA
death	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
after or Its	/Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No	1 ☐ Yes 2 ☑ No Specify:		Specify:
ural',	d by	3 € Widowed 4 Divorced Year or Dates:	De se dentie Union Commetten	16h	White Kind of Business/Industry
III. Z I Z I 3-0030 be filed within 72 hours after death with the Maryland Hygiene. do they then "ratural", or itema 23a or 28a-f show do ther then "natural", or itema 23a or 28a-f show avent, it a Madical Examinar must be notified at	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)	ring 16b.	Kind of business/maustry
with energy the transfer of th	duc	Elementary/Secondary (0-12) College (1-4or 5+)	emaker	Ox	wn Home
filled Hyg other	0	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide	an Sumame)
ked be	ToB	Charles Bradley Pennington Sr.	Emily (nmn) Litt	lewood
s ma		,	Mailing Address (Street and Number or Run		
and 2 auth n 27 i			2 Brandy Drive, Fore		
of He item		1 ☐ Burial 2 Stremation 3 ☐ Removal from State	crematory or other place)		Location - City or Town, State
Deficiency Sermit. Pages Department of mportant: If it sny Injury or o		4 Donation 5 Other (Specify) Hillto	p Service Corp. 9-5		wson, Maryland
DEMILITIONEY, INICITY FIGURE A LATE 13-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The man and Hygiene are the man and the man and the man and Injury or other traumatic svant, trainfield Examinating must be notified at angle.		21. Signature of Funeral Service Licensee	McComas Funeral Hor		
		23a. Part 1. Ehler the disease, or complications that caused the death. Do not	1317 Cokesbury Road	d, Abingdor or respiratory arrest,	n, Maryland 21009 Approximate Interval Between
		shock, or heart tailure. List only one cause on each line.			Onset and Death
Physician /Medical		disease or condition resulting in death) a. Ong estive to Due to (or as a consequence of	Feart Failure		years
Examiner					
3'D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury):		
and trans	Examiner	Cause (Disease or injury that initiated events c	n.		
e be executed rsicien and burial-transit	caj E	Due to tot as a consequence of	<i>)</i> .		
- 6 × 6	edica	d			
ath certif	J/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant	- 05		23d. Date of delivery
death death death death	icia	in the past 12 months? 1 Voc. 3 Pho 4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Year
by th	Physician/M	9 Unknown		1	
Ords, P.O. BOX 08 requires that the death certifica een signed by the attending phould be detached for use as the	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		o use contribute to the cause of death? 2 \(\subseteq \text{No} \) 3 \(\supseteq \text{Probably} \) 4 \(\subseteq \text{Unknown} \)
v requir	ted				
HECOTOS he law requires a has been sign tge 2 should be	Completed			24a. Was an autopsy performed2	24b. Were autopsy findings available prior to completion of cause of death?
tage				1 Yes 2	
Of VICAL Physician: This certificat rat director, pa	o Be	25. Was case referred to medical examiner? Hospital:	0.5	th (Check only one)	6 Nother (Specify) Assisted
Phy raths	-	27. Manner of Death 28a. Date of Injury 28b. Ti	me of 28c. Injury at	28d. Describe how in	
Attending r death.	atior	1 Natural 5 Pending (Month, Day Year) In 2 Accident investigation	jury Work? M 1 ☐ Yes 2 ☐ No		
	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, far building, etc. (Specify)	π, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
Hospital or At 24 hours after of \$ Funeral Directetely filled in by		29a. Certifier Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place	, and due to the cause	s(s) and manner as stated.
Lothe Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.			
To the within To the comple	Me	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
		flu cy mo	053186	Se	ptember 1,2006
le		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1 - n.n	Daniel
	10	31. Date filed (Month, Day, Year) 32. Redistrar's Signature	vicinui 14d bel	HT IND	01017
Sta Registi		30. Name and address of person who completed cause of death (Item 23a) (JULIE TAMEY MD 615 W. 31. Date filed (Month, Day Year) SEP 0 6 2006 32. Registrar's Signature	poli		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O O C

		-	For State Registrar	;	State of Marylan	o / Departme <i>Certific</i> a	ent of Health and N ate of Death	nentai mygier Reg. t		28024
	Physicia	an l	1. Decedent's Name (First		(_		Day Year	3. Time of Death
	/Medic	al	A R C H I S 4a. Facility Name (If not in				J R ty, Town, or Location of Death	SEPTEMBE	R 4, 2000 4c. County of Deat	0
	Examin	er	NORTH WE		to SPITAL	10.0	RANDALLSTONA		BALTIN	
	Funeral Director		5. Social Security Number 220 - 82 - 75	r 6. Sex	7. Age (In yrs. I	ast birthday) If Un Mont	der 1 Year If Under 24 Hrs.	8. Date of Birth (Month Day, Ye	9. Birt	hplace (State or Foreign untry)
			Usual Residence of Dece	dent	100 Cib	T or I costion		10 11		10d. Inside City Limits
	a-f ahow	ctor	10a. State 10b.	Balti	more 100. Clip	Town or Location	Hill			1 ☐ Yes 2 No
	h with the	al Director	10e. Street and Number	rlswo	ad Circle	10f.	21244	10g.	Citizen of What Co	untry?
350	72 hours after death with the Maryland natural', or Itema 23a or 28a-f ahow disal Examinar must be netilifiad at	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4	2 Marned	2. Was Decedent Ever in U. Armed Forces? 1 Dives 2 □ No 11 Yes, Give Year or Dates:		cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto s 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
215-0036	c * 2	Completed	15. I (Specify on Elementary/Secondary	Decedent's Educate hy highest grade	ation completed) Cellege (1-4or 5+)	life. DO NO	work done during most of wor Tuse retired)	king 16b	kind of Business	Industry lle
LZ D	be filed within tal Hygiene. d other than event, the M	e Cor	17 Father's Name (First,	Midele, Last)	IYr.	Case	Manager 18. Wither's Nan	ne (Firşt, Middle, Maid	Mmun.+(College
ylan		To Be	Archie	W. H.	II, 5r.		Onie	. Holco		T. O. d.
Maryland	s 1 and 2 should f Health and Mer Item 27 le marke other traumatic		Onie R. Am	Reationship (Typ	Mother .	19b. Mailing Add	as worth	Nay, Bal	timore	MD 21239
Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 □ Cre 4 □ Dovation 5 □	emation 3 Re	moval from State	Place of Disposition (semetery, cremator	Name of other place)	1-2006	Location - City or	Town, State
Baltii	permit. Pag Department Importent: I any Injury o		21. Signature of Fundra			2Vt0	01000	no Fune	stown.	VICAS VD 21133
			shock, or heart fail	ure. List only one	ations that caused the deat cause on each line.	h. Do not enter the	mode of dying, such as cardiac		3,000	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a.	Due to (or as a conseq	esperatory	distres sy	drome		days
ı	Examiner		Saquentially list condition	ns. b.	- vente	myseardia	l imparction			nunutes
	nsit	Examiner	if any, leading to immed cause. Enter Underlying Cause (Disease or injury	iate J	Due to (of as a conseq	ue⊣o≘ ot):	10			
90,	ficate be executed physicien and as the burial-transit		that initiated events resulting in death) Last	C.	Due to (or as a conseq	uence of):			1	
68760	ficate to physics the b	edicai		d.						
Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent prediction the past 12 mon 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	gnant ths?	Bc. If yes, outcome of pregnant 1 Live birth 2 Feta 4 Pregnant at time of c	il death 3 ☐ Ectop	ic pregnancy (specify)		23d. Date of de Month	livery Day Year
ds, P.O.	ires that th signed by d be detact	ρ		t conditions con	tributing to death but not res	sulting in the underlyi	ng cause given in Part I.			o the cause of death?
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- Re	The larate has	mo.						performed	? death?	s 2XI No
Vita	ician; certific ector,	Be	25. Was case referred to examiner?	1	ospital:	3500	Other	ath Check only one)		
n of	ing Phys	ion: To	1 ☐ Yes 2 No 27. Manner of Death 1 Natural 5		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	DOA 4 Nursing H 28c. Injury at Work? 1 Yes 2 No	lome 5 ☐ Residenc 28d. Describe how		ecity)
Division of Vital Records,	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Certification:	2 Accident 3 Suicide 6 4 Homicide	investigation Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fa		28f. Location (Stree City or Town, S		lural Route Number,
	Hospital 24 hours a Funeral letely filled	ledicai Co	29a. Certifier 12 (Check only 2	Certifying Phys Medical Examir	ician: To the best of my knier: On the basis of examination and manner stated.	owledge, death occu ation and/or investiga	rred at the time, date and place ation, in my opinion, death occ	a, and due to the caus urred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title	of certifier			29c. License number	29d.	Date signed (Mon	th, Day, Year)
	1) On	for m	ρ.		00059736	Se	plenter	4, 2000
	5		30. Name and address	of person who co	mpleted cause of death (Ite	m 23a) (Type, Print)	HOSPITAL	5401 01	D COUR	T ROAD
	St	ate	31. Date filed (Month, L	ay, Year)	22. Registrar's Sign					
	Regist	rar	CED	0 6 2006	All and Stand Stand	10000				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND, TTEM/8, per FH, C859, 9/8/06, WS
State of Maryland Department of Health and Mental Hygiene
Em#8, per DVR, C859, 9/11/06 TT Certificate of Death 1- For Amend item#8, perDVR, Reg. No. 2006 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day nes **Physician** Kehenia September 4 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital Baltimore 8. Date of Biet 2/3/1925 9. Birthplace (State or Foreign Country) (Month, Data Veal 1925 U.S. Virgin Islamls If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 80 Months Days Hours 1 □ M 2 KF 580-01-7310 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State th and Mental Hygiene. 17 is marked other then "natural", or Iteme 23a or 28e-f ehow traumatic event, the Medical Examinar must be notified at Thomas, Virgin Islands 1 Yes 2 No NA NA Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 91-92 00801 St Thomas, death Completed by Funeral 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Itimore, Maryland 21215-0036 BLACK Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SalES 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fil ment of Health and Mental H tant: If Item 27 Is marked otl MARCELLE John FrANCIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3422 Retlaw Rd, BAHMORE, MD 21207 19a. Informant's Name/Relationship (Type, Print) LYdiA JACKSON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sept 14,200 permit. Page Depertment of Important: If eny injury or once. 4 Donation 5 Other (Specify) 21. Signature of Furn ral Service Licensee SOSEPH H. Brown, 2140 N. Fultonave, Balton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Infarction Acute **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4 Pregnant at time of death signed by the at d be detached fo 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has b lirector, page 2 s 2 No 1 Yes 2 No 1 ☐ Yes Division of Vital To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case eferred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 VOutpatient 3 DOA 1 🗌 Inpatient 27. Manner eath 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Unitural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier September 4, 2006 M.D. 00054482 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wast Bolvedera Ava Baltimora, MO 21215 Patrick McGinley M.D. 2401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OBJECT: SEP 0 6 2006 Registrar

			1 - For State Registrar	ate of Maryland		rtment tificate			nd M		iene .g. N2006	28026
**	Physici	e an	1. Decedent's Name (First, Middle, Last)	TT						2. Date of Deat Month	h Day Yea er 1, 2006	
	/Medic Examir		Frank H. Holquist 3 4a. Facility Name (If not institution, give stree			4b. City, 1	Fown, or l	ocation of		зерсе шье	4c. County of De	
100	Lxaiiii	Ç.	Johns Hopkins Bayvie	2W			altim	ore			n/a	
	Funeral Director		5. Social Security Number 6. Sex 1215-60-7309	7. Age (In yrs. la 2□ F 54		If Under Months	1 Year Days	If Under 24 Hours	4 Hrs. Min.	8. Date of Birth Month, Day, 7/17/52	Year) 9. B Mar	irthplace (State or Foreign Country) Yland
	ow II		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation						10d. Inside City Limits
	Mary a-1 sh	tor	Md n/a		Baltin	nore						1 Tyes 2 No
	or 28	Olrec	10e. Street and Number			10f. Zip				11	0g. Citizen of What	Country?
	s 23a	ral	1915 Frederick Avenu	1e Vas Decedent Ever in U.S	12.1		21223		12/500	of Veneral	USA	nerican Indian.
10	ther de	Funeral Director	1 Never Married 2 Married 1	Armed Forces? ☐ Yes 2 KNo					Puerto F	cify Yes or No- Rican, etc.)	Black, Wi	
93	ral', o	þ	3 ☐ Widowed 4 ☐ Divorced	f Yes, Give Year or Dates:	1	I□Yθs 2	22×No	Specify:			Specify: V	Mhite
5-0	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-1 show the Madical Exempter must be notified at	etec	15. Decedent's Educatio (Specify only highest grade cor	n n pleted)	16a. Deced (Give	lent's Usua kind of won DO NOT us	k done di	ion <i>iring</i> most o	of workin	ng .	16b. Kind of Busines	s/Industry
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br	12 should be filed within in and Mental Hygiene. 7 Is marked other than "I traumatic event, the Med	Be C	17. Father's Name (First, Middle, Last)				-	18. Mother	's Nam <i>e</i>	(First, Middle, N	Maiden Sumame)	
ylaı	Duid b Menta arked	To	Frank Hugo Holquist		1				Laud		7 Shue	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. mportants if item 27 is marked other than "natural", or items 23e or 28e-1 show may injury or other traumatic event, the Medical Examinal must be pullified at 20.5.		19a. Informant's Name/Relationship (Type, I		19b. Mailin	-					, City or Town, State $ m Md.~212$.	
	Health tem 27 other tra		Shirley Ann Holquist 20a. Method of Disposition	20b, Pl	ace of Dispo	sition /Nam	e of	- 1		7	20c. Location - City	
E O	Pages nent of I int: If its		1 ☐ Burial 2 ☆ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State Baff	m <i>etery, cre</i> m Timore don Pa	"Crem rk	ator	9 @ 9	/ 7/	06	Baltimore	, Md.
Baltimore,	permit. Page Department o Important: If any Injury or once:		21. Signature of Funeral Service Licensee				d Apdress			Home		-
	897.29										e, Md. 21	
	Physician /Medical		23a. Pant Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)	LeRow A	-Ry	AR	or aying.	Ry		SEAS	_	Approximate Interval Between Onset and Death
	Examiner		1.7	CALLES T	- / 1/ F	14	EA	RT	6	FAIL	CRIRE	
	D/1/=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):	00						
	ite be executed ysician and ne burial-transit	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):	FFC	95	104	<u> </u>			
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	To th To th comp	Me	29b. Signature and title of certifier	- /-		29c.	. License	number		2	9d. Date signed (Mo	nth, Day, Year)
			· Sovinder	te Tully	MO)	1) 2	271	88	7	4/5/2	5
	1		30. Name and address of person who compl	eted cause of death (Item	23a) (Туре,	Print)	Pla	10	1	mho	110 nna	7/791
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signat	lure	and !	140	c d	s U	/WCl	15 1910	L1 LLV

			For State Registrar	State of Maryland		artment of tificate of			eneZUUt 9. No.	28027
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia		Ilse S. Horva	ath				Septemb	per 3,200	06 7:50 P™
	/Medic Examin		4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town	, or Location of Death		4c. County of Dea	th
			26 Hillside Ct				ninster		Carrol	<u>l</u>
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Day		8. Date of Birth (Month, Day,	Year) C	thplace (State or Foreign ountry)
	Director		219-62-0774	69	Yrs.			JUN 10,	1937 A	ngola
	pu *	-	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	daryla	ō	011			Westmin	stor			1 ☐ Yes 2 X No
	28a-1	Director	Maryland Carroll 10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	with and		26 Hillside Court	-			21157		German	nv
	leath	era		. Was Decedent Ever in U.	S. 13.		f Hispanic Origin? (Spuban, Mexican, Puerto	pecify Yes or No-	14. Race - Am	erican Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other then "naturel", or itema 23a or 28a-f show important: If item 27 is marked other then "naturel", or itema 23a or 28a-f show any Injury or other traumatic event, Ita Modical Esanitrar must be notified at ange.	by Funeral	1 ☐ Never Married 2 █ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	ļ	lf Yes, specify Ci 1 ☐ Yes 2 💢 N		Hican, etc.)	Specify:	nite
ğ	2 hor	Completed	15. Decedent's Educa	ation	16a. Dece	dent's Usual Occ	supation ne during most of work	kina	6b. Kind of Business	
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Baltimore,	it. Partitant	1	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ucensed				dress of Facility Cre			
Ba	Department of the popular of the pop		Edward A. Grego	your			erick Road			1228
	Physician		23a. Part1. Enter the disease or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death cause on each line.	n. Do not en	rer the mode of d	fying, such as cardiac	or respiratory arre	ANO-	Approximate Interval Between Onset and Death
П	/Medical		resulting in death)	Due to (or as a conseq	uence of):	(444	. , 1		
	Examiner		Sequentially list conditions. b.	CNCI	NO	1~174)			
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	icate be executed physician and s the burial-transit	cam	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):					
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ı of		T: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. I	njury at Work?	28d. Describe ho	w injury occurred	
<u>.</u>	Attending in death.	atic	1 Natural 5 ☐ Pending 2 ☐ Accident investigation			M	I □ Yes 2 □ No			
Division	i Si te o	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, s fy)	treet, factory, offi	се	28f. Location (St City or Town	reet and Number or a n, State)	Rural Route Number,
	To the Hospital or At within 24 hours after of the Funeral Direct or Completely filled in by	Medical C	29a. Certifier Certifying Phys (Check only one)	ician: To the best of my known: On the basis of examination and manner stated.	owledge, dea ation and/or i	th occurred at th	e time, date and place ny opinion, death occi	a, and due to the curred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the within the post of the	Me	29b. Signature and title of certifier			29c. Lic	ense number)	9d. Date signed (Mo	nth, Day, Year)
)			\bigcap	الادرو	/	7/0/2	2006
1	D D		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type	, Print)			+ t - t - C	
0	L		Yousut A. Gaffar,		ssroa	ds Drive	e, Ste. 34	O Owings	Mills, MD	21117
п	St Regist	ate	31. Date filed (Month, Day, Year)	22. Registrar's Sign	ature	alle o				

			1 - For State Registrar	State of Maryland	d / Depa	artment rtificate	of H	ealth a Death		R	ag. No. Z	006	28028		
	Physici	an	1. Decedent's Name (First, Middle, Las	HACKERMAN						2. Date of Deal Month AUGUST	28 28	2006	3. Time of Death		
	/Medic Examir		4a. Facility Name (If not institution, give					Location of	f Death	1085000	4c. Cou	unty of Death	3 1 3		
	Funeral Director		5. Social Security Number 6. St 216-32-5371 1 Usual Residence of Decedent	7. Age (In yrs. Ia 7. Age (In yrs. Ia	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day) Nov. 1	2, 19	Coun	ace (State or Foreign try) Cyland		
	death with the Maryland ima 23a or 28a-f ahow ir must be notified at	lirector	10a. State 10b. County MD Anne Art 10e. Street and Number	undel Bro	, Town or Lo		Code			1	0g. Citizen	of What Coun	0d. Inside City Limits 1 ☐ Yes 2 No try?		
9036	ours after ral', or its Examine	by Funeral Director	104 Cedar Hill 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Road 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 Xe No 1 Yes Give Year or Dates:			rfy Cuba	spanic Orig n, Mexican, Specify:	gin? (Spec Puerto R Whit		14.	USA Race - Americ Black, White, o ecify: Wh	etc.		
121215-0036	s 1 and 2 should be filed within 72 hours afte I Heelth and Mental Hygiene. Item 27 Is marked other than "naturel", or I other traumatic event, Ins Medical Exami	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12	de completed) College (1-4or 5+)	(Give	dent's Usual kind of word DO NOT use nt/Cli	k done d e retired,	u <i>ring</i> most Drive	er	(First, Middle, I	Hosp:		lustry		
Maryland	hould be find Mental H marked ot matic aver	To Be	17. Father's Name (First, Middle, Last) Soloman Hackerma 19a. Informant's Name/Relationship (7)		19b Mailir	ng Address	(Street a	Soph:	ie Go	oldstei: Route Number	1		Code)		
_	1 and Heelth Iem 27 other ti		Janet L. Hackern	an - Wife Removal from State	104 ace of Dispo	Cedar esition (Nam matory or oth	Hi ne of her place	L1 Roa	ad Br	ooklyn	Fark,	MD 21	225 wn, State		
Baltimore	permit. Pages Depertment of Important: If it any Injury or once.		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen	Schlange	ro Cre	remat 299 Fr	Addres 10n eder	Society Societick I	ety o Road	, 06] f Mary] Baltimo	land, ore, N	nore, M Inc 12122	D 8		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused the death one cause on each the. PNEUM (a	AIMO	er the mode	of dying	g, such as o	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death		
8760,	ate be executed hysicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Cue to (or as a consequite. Due to (or as a consequite.) Due to (or as a consequite.)											
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	requires that the een signed by th hould be detache	d by Pr	Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Path Chikomic Obutkuchuc Pulmonary Disease								oacco use d		Tip Code) 11.22.5 Town, State MI) 2.28 Approximate Interval Between Onset and Death Very Day Year the cause of death? obably 4 Unknown topsy findings available completion of cause of 2 No city) Ital Route Number, stated. to the cause(s) 7. Day, Year) 7. 2000		
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Vita	ilcian: certific rector,	Be	25. Was case referred to medical examiner?	Hospitaf:			Othe			(Check only on					
ion of	To the Hospital or Attanding Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	ition: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		Bc. Injury Work	at	28		idence 6 Other (Specify) how injury occurred				
Divis	s after dear al Director of in by the	Certification:	3 Suicide 6 Could not by determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	Hospi 24 hou Funer etely fill	edicai		ysician: To the best of my knowniner: On the basis of examinate and manner stated.											
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4	5		30. Name and address of person who De. Mamatha PR	abhakar, 3001,	S. Ha	mover	Str	æt, b	Baltin	nove, h					
	Sta Regist		31. Date fited (Month, Day, Year)	32. Registrar's Signat	ure	de!									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 28029 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 10:45 A M August 30, 2006 Dolores Ann Burgner Hixon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 37 Cedarhill Road Randallstown Baltimore 8. Date of Birth (Month, Day, Year)
Sept. 22,1937

9. Birthplace (State or Country)
Pennsylvania 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 1 F 68 Yrs Director 187-30-1402 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits - how Pages 1 and 2 should be filed within 72 hours after death with the Maryla nant of Health and Mantal Hygiene.

and of Health and Mantal Hygiene.

and it if item 27 is marked other than "natural", or iteme 23s or 28s-f ehow ury or other traumatic event, its Madical Estruitae must be notified. West Berkeley Yes 2 No Falling Waters Funeral Director Virginia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 107 Mobile court 25419 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 DXNo Specify: Be Completed by Specify: White 3 ☐ Widowed 4 ☑ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Management-Bookeeping 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) George E. Burgner Mary C. Bean ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Hixon/ Daughter 37 Cedarhill Road, Randallstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages. Depertment of himportant: if its any injury or of other. West Arunden Crematory August 31 Odenton, MD 1 ☐ Burial 27 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rendon-Bailey Funeral Home, P.A. Signature of Funeral Service Licenses 2818 E. Baltimore Street, Baltimore, MD 21224 23a. Part1 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LING Cancer Physician Morotas disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medicai IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Day 4 □ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy rmed? 2X No certificate 2□ No 1 Tes or Attending Physician: the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPICE Medical Certification; To 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1X9Natural i Director: A 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a
To the Funeral I
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30 2006 D58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St BATMORE ND ZIZOY AARON CHARLES, MO 6601 N_{i}

State Registrar

31. Date filed (Month, Day, Year)

SEP 0 6 2006

DHMH 17 Rev 1/2001

32. Registrar's Signature

29 Market

State of Maryland / Department of Health and Mental Hygien 2005 28030 For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Hill Ž9, 7:40 P M Physician Q. AUG Alicia 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner LAPLATA CHARLES CIVISTA MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Hours 1 ☐ M 2 🔀 F 1941 579-56-9092 64 Nov. Wash, 11, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10b. County 28e-f show traumatic event, the Medical Examiner must be notified at 1. Yes 2 □ No Clinton Prince Georges Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20735 USA 'natural', or iteme 23a or 10313 Wooden Bridge Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 11 Marital Status 1 ☐ Never Married 2X Married Black 1 ☐ Yes 2 No Specify: Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: if item 27 is marked other then "nt eny injury or other traumatic event, if a Modit one. Elementary/Secondary (0-12) 12th College (1-4or 5+) Federal Government Administrative Assistant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gaynail Quarles James Ouarles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 10313 Wooden Bridge Lane; Clinton, MD. Edward Hill/Son 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Park Sept. 5,2006 Landover, MD. 4 □Donation 5 □ Other (Specify) Pope Funeral Homes 5538 Marlboro Pike Forestville, Md. 22. Name and Address of Facility Forestville

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cere Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificete be executed burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical attending physic IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ▼No 3 Ectopic pregnancy Month Day 5 Other (specify) 4☐Pregnant at time of death signed by the a Yes P.0. 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 21 No 3 Probably 4 Unknown cate has been signated page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ho 24a Wasan 1 Yes 2 DINO this certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 1 Yes 2 No P 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) Certification: 27. Manney of Death 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 - Homicide To the Hospitel 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30 D-45737 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIRMALADEVI JAYANTHAN MD 3328 OLD WASH, RD, WALDORF, MD 20602 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2006 28031 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Gilford Harold Hennegar 11:30 AMSeptember 1, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 6110 Bellinham Ct., Apt. 622 **Baltimore** Baltimore | Months | Days | Hours | Min. | Sept. 27, 1921 | Indiana 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1X M 2□F 84 Yrs. 314-20-2673 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County r than "natural", or Items 23a or 28a-f shov the Macical Examiner must be natified at 1 ☐ Yes 2 ▼No Director N/AMaryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21210 U.S.A. Apt. 622 238 6110 Bellinham Ct. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ♥ 1 Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) Building Supplies Specialist Building Supplies permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygien Important: If Item 27 Is marked other It any njury or other treumatic event, Its once. 5+ years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marie Long 2 Gilford Harold Hennegar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21210 19a. Informant's Name/Relationship (Type, Print) 6110 Bellinham Ct. Apt. 622 Baltimore, Maryland (wife) Jane Hennegar 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Pk. 9-7-06 Sykesville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc 6500 York Road Baltimore, Maryland 21212 Perrans 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE MYOCARDIAL INFARCTION **Physician** hours disease or condition resulting in death) /Medical Examiner CORUNARY DISGASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner sicien and burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Vital Records. DIABETES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown Be Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an CANCER OF THE 1 Yes 2√ No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home STResidence 6 Other (Specify) Certification: To 1 ☐ Yes 25 No Division of 27. Magner of Death 28c. Injury al Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Natural 2 Accident death. 4 hours after death Funeral Director: A investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0015462 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200E. 33 dSt #640 BALTO MD MIGUEL KARACUSCHANSKY 32. Registrar's Signature استعان التانيات Registrar

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1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, Slate) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 29d. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Y		lian: T an: T rifficat ttor, pa		25. Was case referred to Medical		26. Place o			
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) To Find the second of the se		Jing Ling After funer	tion:	1 Natural 5 Pending (Month, C	ay Year) 286. Time			injury occurred	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) To Find the second of the se	250	UNISIC	ertifica	3 Suicide 6 Could not be 28e. Place of I					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) To Find the second of the se	3	e Hospita 24 hours e Funera etely fille		(Check only 2 Medical Examiner: On the basis	of examination and/or	eath occurred at the time, date and r investigation, in my opinion, death	place, and due to the cau occurred at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)
	•	To the To the compl	Me	29b. Signature and title of certifier	Mo	29c. License number	r S		
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar SFP 0 6 2006	•	10		T.FLI SE	10 ml4	~ pl-)	Rtulle	MO	21254
		4564 363 24		31. Date filed (Month, Day, Year) 32. Regis	tran's Signature	Garle		•	

State of Maryland / Department of Health and Mental Hygiene 2006 28033 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2, Month **Physician JOHN** CARL HALE September 9:39 P.M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** St. Joseph Medical Center Baltimore Towson 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□ F 53 Maryland Director 214-48-1319 1953 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits if Heelth and Mental Hygiene. Item 27 Ie marked other then "natural", or Iteme 23a or 28a-1 ehow other traumatic event, the Medical Examiner must be notified as 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 McKim Ave. 21212 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1972–74 Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. should be filed within 72 hours after de. It and Mental Hygiene. 11. Maritaf Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 years Engineer Consulting Environmental Consultant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Hale ဂ္ Leona Pages 1 and 2 should Jerns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ra'Nell Davis Hale (wife) 7 McKim Ave. Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 = 6 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment of Important: If eny injury or once. Green Mount Crematory 9/4/06 Baltimore, Maryland Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteriosdenotic Cardiovascular Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, ℧ Due to (or as a consequence of). as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ò Month Year Day 4☐Pregnant at time of death 5 Other (specify) should be deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 2 No 1 Yes 1 Yes ours after death.

neral Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner?
1 ★ Yes 2 □ No 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28b. Time of fnfury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year, 28d. Describe how injury occurred 1 Naturaf 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho To the Func Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 3 2006 20 30. Name and address of person who completed cause of death (Item 20a) (Type, Print) 6 Trimble Hill CT. Lutherville, MD

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day

2006 Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene 2006For State Registra 1-Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 6:05am **Physician** homas M. SEPTEMBER 2, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1508 PHOENIX ROAD BALTIMORE PHOENIX 8. Date of Birth (Month, Day, Year) 12/03/1956 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**∑**M 2□F 49 Yrs. 212-70-9396 MARYLAND **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ed other than "natural", or Itema 23a or 28a-f ahow event, the Medical Examiner oust be nutified at 1 ☐ Yes 2 XNo Director MD BALTIMORE PHOENIX 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1508 PHOENIX ROAD 21131 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MEAT DEPT. MANAGER MEAT GROCERY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be item 27 la marked o WILLIAM HAFEY HYLE, SR. MARGUERITE DADE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) KATHLEEN HYLE 1508 PHOENIX ROAD, PHOENIX, MD 21131 wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 9/11/2006 HAMPSTEAD, MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CARROLL CREMATION * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HENRY W. JENKINS & SONS CO 21. Signature of P ne A Service Licenses 16924 YORK RD. MONKTON, MD 21111 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hernational Nemelogic Structure **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Du to (or as a consequence): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner D, o executed Glioblastomo Due to (or as a consequence of): Box 68760, Hospital or Attanding Physician: The law requires that the death certificate be by Physician/Medical 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed been 24b. Were autopsy findings available prior to completion of cause of death? pain certificate has autopsy performe 2 □ No 1 Yes 2 No 1 TYes edema 25. Was case referred o medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No death. thours after death 2 Accident investigation NA NA 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier fellow 29c. License number neuro-oncology 2 FLORIDA= Thunbar Ho # 88466 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jrm 14-16 Baltimare +CRB-Z 1550 Orleans Street 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

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State of Manyland / Department of Health and Mental Hygiene Q Q Q C

		4	1- State of Maryland / Department of Health and Merital Hygierie 2006 28035
	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3. Time of Death Month
1	/Medic Examin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
8	7		Saint Joseph Medical Center Towson Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 1232-60-1719 13
	nyland ihow		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	8a-f	ecto	MD Baltimore Farkville
	th with t	ai Dir	106. Street and Number 8728 Lackawanna Avenue 107. Zip Code 21234-3506 U.S.A.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Modical Examiner must be notified at ance.	by Funeral Director	11. Marital Status 1
5-0	72 ho natur	eted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
121	within ene. than the M.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) X-Ray Technician Medical
DQ 2	e filed al Hyg other vent,	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
ylaı	ould b	2	Orval Hovatter Ruth Cathell
Maryland	id 2 sh ith and ith and 27 Is m traum		19a. Informant's Name/Relationship (Type, Print) Sonia R. Hovatter / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8728 Lackawanna Ave.; Baltimore, MD 21234-3506
	of Heal		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
Baltimore,	Page ment cant: If tant: If		4 Donation 5 Other (Specify) Metro Crematory, Inc. 09/05/2006 Catonsville, MD
Ball	Depart Import ony in		21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Johnson Funeral Home, P.A. 8521 Loch Raven Blvd.; Towson, MD 21286
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) CARDIOGENIC SHOCK
	Examiner		Due to (or as a consequence of): MYDCARDIAL INFARCTION
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury
6	tificate be executed g physicien and as the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
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	artifica ing ph e as th		IF FEMALE:
.O. Box	res that the death certificate be executed igned by the attending physicien and be detached for use as the burial-transit	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown
٥.	requires that the een signed by the nould be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PULMONARY EDEMA 1 Yes 2 No 3 Probably 4 Unknown
Records,	. 0.7	Completed	
I Re	The ate h page	Som	24a. Was an autopsy findings available autopsy performed? 1 Yes 2 No 1 Yes 2 No
Vital	Physician: this certific al director,	Be	25. Was case referred to medical examiner? Hospital: Other Cartesian Control of Check only one)
ō	ng Phy fter this neral d	tion: To	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
Division	l or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 4 Homicide 3 Could not be determined 3 Suicide 4 Homicide 4 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: All completely filled in by the fu	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the within To the Comp	W	29b. Signature and tittle of centrifier 29c. License number 29d. Date signed (Month, Day, Year)
	,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	10+1		TIMOTHY LOW M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204
kų,	Sta Regist	ate rår	31. Date filed (Month, Day, Year) 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 200628036 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 4 **Physician** 11:30 PM 2006 ELIZABETH HEIMERT HUNTER /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner KESWICK HOME BALTIMORE
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 € F Yrs. 218-34-1100 Director 88 2/1/1918 MARYLAND Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depriment of Heelih and Mental Hygiene. Importent: If item 27 is marked other than "natural" ~ " any njury or other traumatic average. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Director BALTIMORE LUTHERVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1621 TREBOR COURT 21093 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Marned 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) WARD MACHINERY 12TH GRADE BOOKKEEPER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ALBERT EDWARD HEIMERT, JR. KATHERINE TERESA HOLMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TIMONIUM, MD DONALD SCOTT HUNTER, JR./SON 410 IVY CHURCH ROAD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State LOUDON PARK CEMETERY 9/7/2006 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign turn of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final melle **Physician** disease or condition resulting in death) /Medical **Examiner** theroscleratio cardionas cular Tears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine V to the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the ettending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregna 3 □Ectopic pregnancy in the past 12 moe 1 ☐ Yes 2 ☐ No ŏ Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à page 2 should be 2 12 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 No After this certification funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 1 ☐ Yes 2 ☑ No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28c, Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending efter death. I Director: Aft d in by the fun 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours e To the Funeral C 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death opcurred at the time, date and place, and due to the course(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 013657 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ,700 W. 40th STREET, BALTIMORE, MD 21211

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

Joseph

MACGREGOR

2006

32. Registrar's Signature

			For State 1 - State Registrar	ate of Marylan	nd / Depa <i>Cer</i>	irtment of H <i>tificate of l</i>	lealth and Death	l Mental Hy	gien Reg. N	2006	28037
	Physici /Medic		1. Decedent's Name (First, Middle, Last)		HOI	4N62		2 Date of D Month	eath	2 UZ *30	3. Time of Death
	Examir Funeral Director		4a. Facility Name (If not institution, give street The Johns Hopkins 5. Social Security Number 6. Sex 1 □ M 2	Hospital	last birthday) Yrs.	4b. City, Town, or tf Under 1 Year Months Days	MONE OF DE LOCATION OF DE	rs. 8. Pate of Bi	irth	N/A 9. Birth Cou	place (State or Foreign ntry) t Nam
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	e Mar	Director	Maryland Howard	Co	lumbia						1 ☐ Yes 2 X No
	with th		10e. Street and Number			10f. Zip Code			-	itizen of What Cou	•
	death ms 23	Funerai	6757 Sewells Orchard 11. Marital Status 12. W	as Decedent Ever in U	J.S. 13. V	21045 Vas Decedent of Hi Yes, specify Cuba	ispanic Origin?	(Specify Yes or N		ted Stat 14. Race - Ameri	can Indian,
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. dother than "naturel", or items 23a or 28a-f ehow event, the Medical Examinar must be notified at	þ	1 Never Married 2 Married 1	med Forces? □Yes 2 X No Yes, Give ear or Dates:		Yes, specify Cuba	Specify:	erto Rican, etc.)		Black, White, Specify: Asi	
15-0	"natu	jetec	15. Decedent's Education (Specify only highest grade com		16a. Deced	lent's Usual Occupa kind of work done of OO NOT use retired	ation during most of w	vorking	16b. I	Kind of Business/In	ndustry
212	d within giene. or than "	Completed	Elementary/Secondary (0-12) Co	ollege (1-4or 5+)		emaker	,		O	wn Home	
	be filed tai Hygid d other event, II	Be B	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle	e, Maide	n Sumame)	
Maryland		၉	Hoang Thanh Huan 19a. Informant's Name/Relationship (Type. P.	nint)	19b Mailin	g Address (Street		Thi Tra		or Tourn State 7	n Codel
	nd 2 lith a 27 is r tra	:	Nhung Hoang Pho/Daug	,		•					yland 21045
Baltimore,	Pages 1 arment of Hearlant: if Item		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	20b. F	Place of Disponent Cometery, cremetery, cremetery	sition (Name of natory or other place y um, Inc.	se) Sep	tember 2006	20c. L	ocation · City or T	own, State
Balti	permit. Pages 'Department of H Important: If its eny injury or of		21. Signature of Funeral Service Licenses	V.M.	Be	Name and Address	ss of Facility R hevy Ch	obert A. ase, Inc	• 75	phrey Fu	neral Home/ nsin Avenue
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arte	Physician		Immediate Cause (Final disease or condition resulting in death)	RIGHT	HEA	HRT F					Hours
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	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or infury that initiated events	540 to (51 43 4 501364	quanto oi).						
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	sign d b	Ď	Part II. Other significant conditions contribut	ing to death but not res	sulting in the ur	nderlying cause give	en in Part I.		tobacco Yes 2		the cause of death?
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Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	al: 🗸 _	100c	Othe	25	eath Check only			,
ō		n: To	27 Manner of Death 28	a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of	28c. Injury	4 🗀 Nursing	Home 5 ☐ Res 28d. Describe		6 ☐Other (Speci ury occurred	fy)
Division	dea tor the	Certification;	2 Accident investigation	e. Ptace of Injury - At he	Injury ome, farm, stre	M 1	k? Yes 2 □ No	28f. Location	(Street a	nd Number or Run	al Route Number,
ō	To the Hospital or Attendi within 24 hours after death To the Funerel Director: A completely filled in by the fi	dicai Cert	29a. Certifier Physician	building, etc. (Specif	rwiadga: danth	Sociums? at the tim	nu, date and pla	City or To	a calme(r	s) and manner as a	the desired.
	To the Ho within 24 To the Fu completel	Medic	(Check only 2 Medical Examiner: Cane) 29b. Signature and Hitle of certifier	In the basis of examina nd manner stated.	ation and/or inv	/estigation, in my or		curred at the time		ate signed (Month,	
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	+		DANGE KIM	ed cause of death (Iten	DETH	WOLFE	STREE	T BAC	TIM	LORE, MA	RYLLAND 2126
	Sta Registi		31. Date filed (Month, Day, Year) \$FP 0 6 2006	32. Registrar's Signa	B. A	reste					

			1 - For Amend item#20	Da-c,22,per	of Maryla FH, 6859,	nd1/Bene Cei	rtment of F	lealth and Death	Mental Hyg	iene .g. No 200	6 28038			
	Disconing		1. Decedent's Name (First, Middle	e, Last)					2. Date of Deat	h	3. Time of Death			
	Physici /Medic		Willie Holman						August	2^{Day} , 2006	11:50 AMM			
	Examin	er	4a. Facility Name (If not institution		rumber)		4b. City, Town, o		ath	4c. County of [Death			
			Joseph Richey 5. Social Security Number	HOSPICE 6. Sex	7 Age (In vi	s. last birthday)	Balti If Under 1 Year	If Under 24 H	S. R Date of Birth		Birthplace (State or Foreign			
	Funeral Director		215-34-9261	1 ∏ M 2□F	67	Yrs.	Months Days	Hours Mi		1938 V	Country) irginia			
	ס		Usual Residence of Decedent											
	anylan show		10a. State 10b. County		10c. (City, Town or Lo					10d. Inside City Limits			
	Ba-f	octo	MD			Baltimo					1 Yes 2 No			
	or 2	ä	10e. Street and Number				10f. Zip Code	01017	1	0g. Citizen of Wha	t Country?			
	eath	eral	1937 Harlem A		cedent Ever in	U.S. 13 V		21217	(Specify Yes or No-	USA 14. Bace - A	American Indian,			
21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental Hygiene. Importent: If item 27 is marked other then *naturel', or iteme 23e or 28e-f ehow eny Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	1 Never Married 2 Marriad 3 Widowed 4 Divorced	Armed	Forces? 3 2 ⊠ No Bive	1	f Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	erto Rican, etc.)		Vhite, etc. black			
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Maryland	d be f antal h ced of	Be c	Willie Holman							vialuen Sulliallie)				
Ž	shoul nd Me mark	၉	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street	Marie Glover and Number or Rural Route Number, City or Town, State, Zip Code)						
	nd 2 alth a 27 ls		Lonnie Cooper	:/sister		5602	Todd Aver	nue Balt	imore, MD	21206				
J.e.	es 1 e of Hea r item		20a. Method of Disposition	2 Demouslifes	20b	ce)		20c. Location - City						
Ē	Page ment ent: H ury o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	pocify) in S	m State	moriou Cre	amatory	9/7/2006 Baltimore, MD Hari P. Close Funeral Services, P.A.						
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P.O. Box	The law requires that the death certifi ste has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	outcome of preg birth 2 Fe gnant at time of known	etal death 3]Ectopic pregnancy] Other (specify)			23d. Date of Month	f delivery Day Year			
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of \	Physi this c al dire	٥	1 ☐ Yes 2 No	-		☐ ER/Outpatien	t 3 DOA Oth	er: 4 Nursing	Home 5 Reside		Specify) HOSPICC.			
LO C	the free	lo	27. Manner of Death 1 Natural 5 Pendir	ng (Me	e of Injury onth, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 ⊡No	28d. Describe ho	w injury occurred				
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Ö	al or A setter 1 Dire d in b	Certification;	4 Homicide	bui	lding, etc. (Spe	cify)	, , , , , , , , , , , , , , , , , , ,		City or Town	n, State)				
	To the Hospital or Attending within 24 hours effer death. To the Funerel Director: Attecompletely filled in by the fune	Medical (29a. Certifier (Check only one) 1 Certifyir 2 Medical	Examiner: On the	he best of my k basis of exami anner stated.	nowledge, death nation and/or in	n occurred at the tirvestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the ca curred at the time, da	ause(s) and manne ate and place, and	or as stated. due to the cause(s)			
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•	$\langle n \rangle$		30. Name and address of person	who completed an	pet	Y SI CIA	Print)	222-35	-	08/29/	2006.			
	4		ISMOIL A. SHA 31. Date filed (Month, Day, Year)	LARY, UD	PKO.	GIGT N	. CHARLE	s sf &	310, BACT	Torace, or	1)21040			
	Sta Registr	-	SEP 0 6 20	06	J. J.	nature	W Comments							

Amend #196 Please Type 85 Printin Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 28039 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 30, 2006 AUGUS Ernest Johnson 932 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Good Samaritan Hospita Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 05/03/1930 Birthplace (State or Foreign Country) Funeral Days Months Hours 1 □XM 2 □ F 76 Yrs. Director 217-24-4306 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ar then "natural", or Itame 23a or 28a-f ehow The Medical Examiner must be notified at 1 X Yes 2 ☐ No Directo Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 814 Winston Avenue U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. ☐Yes 2 XNo fYes, Give 1 ☐ Never Married 2 ☐ Marned 1 ☐ Yes 2 X No Specify: Specify: Black 3 √ Widowed 4 □ Divorced If Yes, Give Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Painter 8 Health and Mental Hygid Ism 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Johnson Ernest Harris 19b. Maili Market (Seet and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4912 Midway Avenue, Baltimore, Maryland 21212 Paul Johnson / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages.
Department of I Importent: If its eny injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 09/09/2006 Baltimore, Maryland King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility $The\ Derrick\ C.\ Jones\ F/H,\ P.A.$ Signature of Funeral Service Licensee †4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Colon Metastatic Carcinoma **Physician** mon. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Š 1 ☐ Yes 2 1 No 3 Probably 4 □Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 DER/Outpatient 3 □ DOA After the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after d • Funerel Direct 4 Homicide Contifying Physician: To the best of my knowledge, death oppured at the time, date and plane, and due to the nause(s) and manner as stated 29a. Certifier within 24 ho To the Fune completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifies 29d. Date signed (Month, Day, Year) D15546 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rodnett MTD F1001 LOCH RAVEN BIVA, Baltimore,

Registrar

31. Date filed (Month, Day, Year)

2005 32. Redistrar's Signature

SERES ...

			For State Registrar	State of N	Maryland /	Depa Cer	artment of F rtificate of a	lealth and Death	Mental Hy	giene 0	106	28040
Á	Physici	an	1. Decedent's Name (First, Middle, Las	w Johns	ıon				2. Date of De Month	Day	Year	3. Time of Death
	/Medic	100	4a. Fecility Name (If not institution, give				4b. City, Town, o	r Location of De	SEPTE		3, 200 nty of Death	06 2:20 [™] A
			Saint Josep						owson			ltimore
	Funeral Director			9X 7. A	Age (In yrs. last) 82	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		th 19, Year) 1924	9. Birthpl Count New	
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	ocation				10	Od. Inside City Limits
	e Man	ctor	Maryland Harfo	rd			Ве	el Air				1 ☐ Yes 2 XNo
	with the	Director	10e. Street and Number 915 Moores Mil	11 Dood			10f. Zip Code	2101/		10g. Citizen o		try?
	na 234	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U.S.	13.	Was Decedent of H	21014 lispanic Origin?	(Specify Yes or No		USA ace - America	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "neturel", or Itema 23a or 28a-f ehow appringuty or other traumatic event, I'm Medical Exertifical must be notified at ance.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force: 1 X Yes 2 [If Yes, Give Year or Dates	s?] No ::1943 - 45		If Yes, specify Cuba 1 ☐ Yes 2X No	an, Mexican, Pu Specify:	erto Rican, etc.)	Spec		ite
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Maryland	ould b Menta	To	Andrew Johns						Martha Wa			
Mar	d 2 sh th and th sm T is m		Felicia Eleanor Caulfield Johnson	Гуре, Print) - Лэн			ng Address (Street Moores M					Code)
ē,	s 1 an if Heal Item 2 othar		20a. Method of Disposition		20b. Place	of Dispo	psition (Name of matory or other place		Date Del Al	r MD 2 20c. Location	n - City or To	wn, State
altimore,	Page ment c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		(0	Cre	matory,	Inc. 9/	5/06	Balt:	imore,	MD
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			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caus	ed the death. D	o not eni	ter the mode of dyir	ng, such as card	liac or respiratory a	rrest,		Approximate Interval Between Onset and Death
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ot O	Physician: r this certifica ral director, i	2	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpa		Outpatie		4 IAGISITI	g Home 5 Res	idence 6 🗆 C		')
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ivisi	or Attendation of the order of the order of the order	Certification	3 Suicide 6 Could not be determined	28e. Place of	Injury - At home etc. (Specify)	, farm, st	reet, factory, office			Street and Nur wn, State)	mber or Rura	l Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funaral Director: After this certificate his completely tilled in by the funeral director, page	edical Ce	29a. Certifier 1 Certifying Ph (Check only one)		of examination		h occurred at the til					
	To the within To the comple	Med	29b. Signature and title of certifier	. (WO	29c. Licens	e number		29d. Date sign	~ ~	Day, Year)
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Ç.	Sta		RICHARD LINT 31. Date filed (Month, Day, Year)	32. Regi	steads Cinnwitted	Goas	-	Y	HI KILICING		<u>u =1=</u>	.KU4+
OK.	Regist	rar	SEP 0 6 2006	Alpera	1 15 1	S. Jan	V-3					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene A. O. C.

			For State Registrar	State of Maryla	Cer	tificate of	Death		erie 2006	28041
	Physici	an	Decedent's Name (First, Middle, La					2. Date of Death Month	Day Year	3. Time of Death
	/Medio	al	Doris Anna 4a. Facility Name (If not institution, giv			4b City Town o	r Location of Death	Sept.	6 2006 4c. County of Death	12:35 a M
	Examin	er	16 Marsham Ct.	o on our and named,			sterstown		Baltin	nore
	Funeral Director		5. Social Security Number 6. S 215–26–4377	Sex 7. Age (In y. 10 M 2 ■ 75	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 2,	Year) 9. Birth Cou	place (State or Foreign ntry) Land
	and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Maryi	ţo	Md. Baltimo		Reister					1 ☐ Yes 2 ☐ No
	death with the Maryland ime 23s or 28s-f show rinual be notified at	Direc	10e. Street and Number 16 Marsham (Ct.		10f. Zip Code 2113	6	10	g. Citizen of What Cou	ntry?
_	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-1 show any lojury or other traumatic event, its Medical Examination must be notified a more.	/ Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 M No If Yes, Give		Was Decedent of Hif Yes, specify Cuba	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh-	etc.
2-003e	filed within 72 hours after Hygiene. ther then "naturel", or ite ont, the Medical Exertine	Completed by	3	Year or Dates:		dent's Usual Occup		1 1	Specify: Wh:	
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*: .	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):	nocytre	Leuben Leube	er na	July	Veeus
	bed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons		1009110	October 1	7		100)
ρΩ,	tificate be executed by physician and as the burial-transit	al Exan	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):					
68/6 0,	tificate ig phys as the	ledical	1/2	_ d						
O. BOX	death cer e attendir id for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)	у		23d. Date of deliv Month	ery Day Year
cords, P.	requires that the een signed by th nould be detache	þ	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.		acco use contribute to	he cause of death?
Ŭ L	e la has	Completed						24a. Was an autopsy perform	ed? prior to co	opsy findings available ompletion of cause of
VII	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?					h (Check only one	7	
0	W 75	၉	1 ☐ Yes 2 ☐ Ho		ER/Outpatier	IL SU DOA			nce 6 Other (Speci	(y)
	fe fe	ertification;	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	Wor	ry at rk? Yes 2 □No	28d. Describe how	winjury occurred	
	al or Attens s after deat of Director:	Certific	3 Suicide 6 Could not be 4 Homicide determined		At home, farm, str ecify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Rur State)	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical (29a. Certifier 1 Certifying Pl (Check only 2 Medical Exa one)	hysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, death nination and/or in	h occurred at the til vestigation, in my o	me, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner as te and place, and due t	stated. o the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Month,	Day, Year)
•	\sim		Willy 4	Lun		D	205813	7 9	16/6	
	8		30, Name and address of person who	295 Stone	or Are	St 30	7 Wes	tminste	- MD 2	1157
	Sta Registr		31. Date filed (Month, Day, Year) CFD 0 6 20	32 Sepistrar's Si	ignature	whi				

06-06624 Frank M. Jackson

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2006 28042

		Registrar	or Death	Reg.	
Physicia edical Exami		1. Decedent's Name (First, Middle,Last) Frank M. Jackson		September 4	
		4a. Facility Name (if not institution, give street and number) Rossville Boulevard & Yellow Brick Road	4b. City, Town, or Location of De- Rosedale	ath	4c. County of Death Baltimore County
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		⁄lin.	MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		210)2)003	rs. Northis Days Hours	April 3	, 1948 Country) Japan
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	cation		10d. Inside City Limits
Maryland 28a-f show any <u>d at once.</u>	5	MD Harford Edgewood			1 Yes 2 X No
rith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
ith the 23a o notifi	a D	500 Aspen Crt. 11. Marital Status 12. Was Decedent Ever in U.S. 13. V	21040 Was Decedent of Hispanic Origin? (Specify Yes or No-	USA 14. Race - American Indian, Black,
leath w	Funeral		f Yes, specify Cuban, Mexican, Pue		White, etc.
after d	by F	Wildowed 4 Divorced of Page 1 Vietnam 1	Yes 2 X No specify: A		Specify: Asian
5-0036 led within 72 hours after tygiene other than "natural", the Medical Examiner			dent's Usual Occupation (Give kind g most of working life. DO NOT use		6b. Kind of Business/Industry
036 thin 72 ne r than ledical	Completed		ployed		Unemployed
215-0036 oe filed within 7 ntal Hygiene sked other than ent, the Medica		17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, Mai	iden Surname)
- F 5 6 7	To Be	Buford Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number	Jinmaku or Rural Route Numbe	er, City or Town, State, Zip Code)
MD nd 2 sho afth and m 27 is aumatiu			Aspen Crt. Edge	wood, MD 2	21040
nore, MD 2 ages 1 and 2 should ent of Health and M nt: If item 27 is m		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or	position (Name of cemetery, other place)	Date 2	2Cc. Location - City or Town, State
		4 Donation 5 Other Specify: Metro C	rematory S	ep. 6, 06	Baltimore, MD
Balti permit. Departm Imports injury o	ļ	21. Signature of Funeral Service Tidensee	Name and Address of Facility Cremation Societ 299 Frederick Ro	y of Maryl ad Baltimo	and, Inc. ore. MD 21228
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	er the mode of dying, such as cardia	ac or respiratory arrest	t, shock, or heart Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Methadone intoxication			Death
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.			
	iner	if any, leading to immediate Due to (or as a consequence of):			
T its	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	- · · · · · · · · · · · · · · · · · · ·	-	
xecuted n and - transit		d AMENDED			
760, cate be ex physician he burial	an/Medical	X UNPENDED AMENDED item#23a.27.28a	_f.perME.g859.9/20/0	6 IT	23d. Date of delivery
68760, sertificate be ding physicise as the buri	ian/I	past 12 months?	Fetal death 3 Ectopic pre	gnancy	Month Day Year
Box e death c the atter ed for us	Physici	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		
, P.O. Box 68 ires that the death certiff signed by the attending be detached for use as	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I	23e. Did toba	acco use contribute to the cause of death? 2 No 3 Probably 4 V Unknown
IS, P quires t en sign ald be c	ted t				
cords, law requir has been s	Completed			autopsy	ed? death?
Vital Reco ysician: The law his certificate has director, page 2.s	e Col	25. Was case referred to medical	26.Place of Death (Che	1 Yes 2 eck only one)	No 1 V Yes 2 No
Vita nysicia this cer	0 0	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati		rsing Home 5 R	esidence 6 🗸 Other: Scene
Division of Vital Records, tal or Attending Physician: The law require and ard redden as Director: After this certificate has been sited in by the funeral director, page 2 should be	on: T	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Natural 5 Pending R 1 0 // / 0000 R 1 1	1 Ves 2 -No	28d. Describe ho	• •
Sion Attend r death ector: by the	cati	2 Accident Investigation Fnd 9/4/2006 Fnd 1	.1:30 and	28f Location (Str	reet and Number or Rural Route Number. City
Divi	Certification:	3 Suicide 6 X Could not be determined (Specify) found in wooded		Brick Roa	d Bassyille Blyd. & Yellow
Division of Vital Records, P.O. Box 68760, within 24 burs after death certificate be executed within 24 burs after death. To the Funeral Director. After this certificate has been signed by the attenting physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death or one) Medical Examiner: On the basis of examination and/or investigation.	ccurred at the time, date and place, tigation, in my opinion, death occurr	and due to the cause(ed at the time, date ar	(s) and manner as started. nd place, and due to the cause(s)
To with	Mec	and manner stated 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		highi, mo	O.C.M.E.		September 5, 2006
7		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn St	reet, Baltimore, MD 21201		
	tate	SED II E /DIIL	Soul -		
Regis			NAI		
DHMH 17 Rev 1/	2007	ORIGI	NAL		

State of Maryland / Department of Health and Mental Hygien 2006 28043 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** DOROTHY E. JONES SEPT. 2006 6:04A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner PARKVILLE **BALTIMORE** 3121 Hiss Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) Feb. 21,1921 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 217-12-8133 1 ☐ M 2 🕟 F Feb. Maryland Yrs. 85 Director Usual Residence of Decedent 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show rthan "natural", or iteme 23a or 28a-1 eho the Medical Examiner must be routified at 1 ☐ Yes 2 ☑ No Baltimore Parkville - Baltimore County Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 3121 Hiss Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4XXDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. N/A Secretary State of Md. i. Pages 1 end 2 should be filed w tment of Health and Mental Hygie tant: If item 27 is marked other t ijury or other treumatic event. In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George S. Harrison Caroline K. Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2:
Department of Health at important: If Item 27 is eny injury or other treugnos. Leslie Amtmann (Daughter) 3023 Linwood Avenue Baltimore, Md. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 9-6-2006 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Maryland 21. Signature Fu eral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury g physicien and as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year 4☐Pregnant at time of death 5 Other (specify) signed by the e 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death | Check nly on r? 2**2** No Other: 4 Nursing Home Hospital: 57 ۴ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA sidence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) After thi funeral 28d. Discribe how injury occurred 27. Marther of Death 1 △Natural 2 □ Accident 28c. Injury at Work? 28b. Time of Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours after To the Funeral Dire 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai Adical Examiner: On the basis of examinerion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatur who completed cause of death (Item 23a) (Type, Print) 5 Ste 302 Towson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2005

28044 Certificate of Death 3. Time of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 6:40PM **Physician** ROBERT DOUGLAS JEFFS Low /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE 104 GREENSPRING VALLEY RD OWINGS MILLS | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | 07/15/1924 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**☆**M 2□ F 212-82-4511 82 CANADA Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No BALTIMORE OWINGS MILLS Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number ō 104 GREENSPRING VALLEY RD 21117 USA or Items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) College (1-4or 5+) PEDIATRIC UROLOGIST MEDICAL DOCTOR 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be GEORGE DOUGLAS JEFFS EULALIE JEFFS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 • 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: if item 27 ie m any injury or other traum 104 GREENSPRING VALLEY RD. OWINGS MILLS, MD CATHARINE JEFFS(WIFE) 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) THOMAS G. FOREST 09/01/06 OWINGS MILLS, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
HENRY W. JENKINS & SONS CO.
16924 YORK RD MONKTON, MD. 21111 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Due to (or as consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit that initiated events physician and resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 Tes 2 No Division of Vital 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P after death. I Director: After After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di tilled 20a Certifica Centrying Physician: To the best of my knowledge ideath occurred at the time, date and plane, and dire to the netire(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 413 30 August 2006 41 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 PAUL G. AUWAETER M.D. 10753 FALLS RD SUITE 325 LUTHERVILLE, MD. 21093 32. Registrar's Signature 31. Date filed (Month, Day, Year) 6 2006

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of N	Marylai	nd / Depa <i>Cei</i>	artmen rtificat	nt of H e of L	ealth a Death	ind M		jiene (006	28045
	Physic /Medi		Decedent's Name (First, Middle, Last) EVELYN MAGDALE		ON						2. Date of Dea Month		Year 2006	3. Time of Death
	Exami		4a. Facility Name (If not institution, give s GOOD Samous		on) Spiled	l	4b. City,	Town, or	Location of Bally	ma	u		unty of Death	
	Funeral Director		5. Social Security Number 6. Sec. 214-26-6627 Usual Residence of Decedent	M 2√2 F 7	Age (In yrs	. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day 6/4/19	, Year)	Cour	place (State or Foreign htry) YLAND
	death with the Maryland me 23a or 28e-f ehow	tor	10a. State 10b. County MD N/A		10c. C	ity, Town or Lo		СТТ	· · · · · · · · · · · · · · · · · · ·				1	0d. Inside City Limits 1
	th the	Director	10e. Street and Number				10f. Zip					0g. Citizen	of What Cour	ntry?
	ath with	ral	6401 LOCH RAVEN E	BLVD.				21239	7			USA	4	
900	ours after ral', or ite	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Deceder Armed Force 1 ☐ Yes 2 [If Yes, Give * Year or Date:	s? No		Was Deced f Yes, sped 1 ☐ Yes		spanic Orig n, Mexican, Specify:	in? (Spe , Puerto f	cify Yes or No- Rican, etc.)	1	Race - Americ Black, White, ecify: WHIT	etc.
1215-0036	72	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		or 5+)		lent's Usua kind of wo DO NOT us ERICA	rk done a se retired,	ition <i>Juring</i> most	of workir	ng .		of Business/Inc	
d 21	filed Hygie other	a	12TH GRADE 17. Father's Name (First, Middle, Last)			OL.	ILI (I O)		18. Mother	's Name	(First, Middle,		FICE	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, the Me	To B	JOHN HARRIS							Y WIT				
lan,	2 sho and h ls ma		19a. Informant's Name/Relationship (Ty)	oe, Print)		19b. Mailin	g Address	(Street a	nd Numbei	r or Rurai	Route Number	, City or To	wn, State, Zip	Code)
Baltimore, A	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tree		LOIS BATZER/DAUGH 20a. Method of Disposition 1 Disposition 3 DR			4057 Place of Dispo cemetery cren LANEY V		ne of	<i>y</i> !	D		20c. Location	on - City or To	own, State
Baltir	permit. P Departme Importen eny injur:		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	θ			. Name an		s of Facility	THE	JOHNSO	ON FUN		OME, P.A.
	- 福華		23a. Pantt. Enter the disease, or complice shock, or heart failure. List only on	cations that caus	ed the dea	th. Do not ente	527 I	OCH e of dvino	RAVEN	J BLV ardiac or	D. TOV	ISON,	MD 21	286 Approximate
100	Physician buy sician and buy sician and buy sician and buy sician and the bring street	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	Hymu s a consecutive	quence of): Quence of):	lerel	Aut	1 Mu	ollin julat	e Shift Lou-	,		Interval Between Onset and Death
P.O. Box 68760,	Physicien: The law requires that the death certificate be this certificate has been signed by the attending physicia rat director, page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcom 1	2 Feta	al death 3 🗌	Ectopic pri Other (sp						Date of delive Month	ry Day Year
	n requires tha been signed should be del	þ	Part II. Other significant conditions con	thousing to death	but not res	ulting in the un	derlying ca	ause give	n in Part I.			oacco use c es 2□No		e cause of death? ably 4 Junknown
of Vital Records,	: The law recate has be page 2 she	Completed	V							-	24a. Was ar autops perform	V	b. Were autor prior to con death? 1 \(\text{Yes}	osy findings available inpletion of cause of 2 No
Vita	ysicien: Th is certificate director, pag	0	25. Was case referred to medical examiner?	ospital:				! Otho	_		Check only on			
on of	ding h. After fune	tion: To	1	28a. Date of In (Month, D	jury	ER/Outpatient 28b. Time of Injury		8c. Injury Work	4 🗀 (40)	28	e 5 Reside 8d. Describe ho			')
Division	tel or Attendest s after death al Director; ad in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of h	njury - At h	ome, farm, stre	et, factory	, office		28	3f. Location (St. City or Town	reet and Nu , State)	mber or Rura	Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical	29a. Certifier 1 Certifying Phys. (Check only one)	cian: To the bes er: On the basis and manners	OI BXAIIIIII	owledge, death ation and/or inv	occurred a estigation,	at the time in my opi	a, date and nion, death	place, ar	nd due to the ca	iuse(s) and ate and plac	manner as sta	ated. the cause(s)
	To T		29b. Signature and title of certifier		reluit			License	ESOC	00	29	d. Date sig	rined (Month, L	Day, Year)
	M		30. Name and address of person who cor SANDEEP MAUCC	N, Go	2 boi	amari La	1	pulad	56	01,	Loch Ra Baltim		Blud.	21237
	Sta Registr		31. Date filed (Month, Day, Year) SFP 0 6 20	06 32 Regis	trar's Signa	ature	berte	1				,		

Examiner Authority Author	10d. Inside City Limits 1 Yes 2 No n of What Country? U.S.A. Race - American Indian, Black, White, etc. Decify: White of Business/Industry
Edward James Karpowicz \$eptember 2 Medical Examiner Medical Exami	2006 6:49 A M Dunty of Death NA 9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 XYes 2 No n of What Country? U.S.A. Race - American Indian, Black, White, etc. Decify: White of Business/Industry
### Funeral Director Funeral Director Funeral	NA 9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2 No n of What Country? U.S.A. Race - American Indian, Black, White, etc. pecify: White of Business/Industry
Funeral Director Social Security Number S	9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2 No n of What Country? U.S.A. Race - American Indian, Black, White, etc. Pecify: White of Business/Industry
Director State 10b. County 10c. City, Town or Location 10d. Zip Code 10d. Citizen 10d. Zip Code 10d. Zip Code 10d. Citizen 10d. Zip Code	Maryland 10d. Inside City Limits 1 Yes 2 No n of What Country? U.S.A. Race - American Indian, Black, White, etc. Decify: White of Business/Industry
The state of the s	1 Yes 2 No n of What Country? U.S.A. Race - American Indian, Black, White, etc. Pecify: White of Business/Industry
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	mame)
John Karpovich Sophie 19a Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Bural Boute Number, City or To	Kieff
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or To	
	tion - City or Town, State
1 Removal from State 1 Removal from State 4 Donation 5 Other (Specify) September Sacred Heart of Jesus 6,2006 Dunda1	
21. Signature of Funeral Service Lightsee /) 22. Name and Address of Facility	k, Maryland
21. Signature of Funeral Service Liensee 22. Name and Address of Facility W. Dabrowski/Chojnacki Funeral 1005 Dundalk Aye. Baltimore, Ma	Homes P.A,
23a/Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one state on each line.	Approximate Interval Between
Physician Immediate Cause (Final disease or condition a Corollary orlary oliseose	Onset and Death
/Medical resulting in death) Due to (or as a consequence of):	
Examiner Sequentially list conditions, b. Hyfertursor	
Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	0
18-3 2 trad initiated events c. Cococci (cure
9 a legina legin	
The past 12 months? 23d. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 5 Other (specify)	d. Date of delivery
Second S	Month Day Year
1 Yes 2 Mo 9 Unknown Unknown Part Other significant contributing to death but not resulting in the undertying cause gives in Part 239 Did tabasecques a	contribute to the cause of death?
Part II. Other significant conditions, contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 N 24a. Was an 2.	No 3 Probably 4 DUMnown
Some of the state	
1 Yes 2 N 1 Yes 2 N 24a. Was an autopsy performed? 1 Yes 2 N 24a. Was an autopsy performed? 1 Yes 2 N 24a. Was an autopsy performed? 1 Yes 2 N 24a. Was an autopsy performed? 1 Yes 2 N 24a. Was an autopsy performed? 1 Yes 2 N	24b. Were autopsy findings available prior to completion of cause of death?
Performed? 1	1 🗆 Yes 2 🗆 No
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6	Other (Specify)
27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury or Injury Work?	
The second secon	
The color of the	Number or Rural Route Number,
29a. Certifier (Check only Check	d manner as stated. ace, and due to the cause(s)
and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date si	signed (Month, Day, Year)
	mber 5, 2006
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V. Reddy M.D. 115 E. Melrose Ave	21212 e. Balto., Md.
State Registrar 31. Date filed (Month, Day, Year) SEP 0 6 2006 32. Registrar's Signature	

		-		partment of Health and Me ertificate of Death	ental Hygiene Reg. No. 2	006 28047
H	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) DORIS KELOSEL		2. Date of Death Month Day No	Zear 3. Time of Death 4. 20 p M
j	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. Cou	unty of Death
			Northwest Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Randallstown (i) If Under 1 Year If Under 24 Hrs. 8	Date of Righ	9. Birthplace (State or Foreign
	Funeral Director		216–18–3403 1 M 2 DE 82 Yrs.	Months Days Hours Min.	07/29/1924	Country) Maryland
			Usual Residence of Decedent		0,,25,,521	
	how dell		10a. State 10b. County 10c. City, Town or I			10d. Inside City Limits 11⁄2 Yes 2 ☐ No
	Be-f	Director		imore City	10g Citizen	of What Country?
	with t	ā	100. Street and Number	10f. Zip Code 21223		ted States
	ne 23	Funerai	409 Furrow Street 11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R		Race - American Indian,
336	J within 72 hours after deeth with the Maryland Jene. Than "natural; or itams 23s or 28s-f show the Madical Examinat must be notified at		Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto H 1 ☐ Yes 2 ☑ No Specify:	1	Black, White, etc. ec <i>ity:</i> White
Baltimore, Maryland 21215-0036	72 hou	Completed by	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of working	16b. Kind (of Business/Industry
21	within ene.	mple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
72	filed w Hygiei ther ti		8 N/A HC 17. Father's Name (First, Middle, Last)	memaker	(First, Middle, Maiden Sur	Home
and	Mental Harked of	o Be	Earl Smith		e Immler	
ary I	\$ 5 E E	٢		ling Address (Street and Number or Rural		wn, State, Zip Code)
ž	and 2 selth a n 27 le			Bernadette Drive,	Forest Hill,	Maryland 21150
ore	000			ematory`or other place)		on - City or Town, State
Ë	Pages tment of I tant: If its		□Donation 5 □Other (Specify) LOUGON	Park Cemetery 09/06	/2006 Balti	more, Maryland
Bai	permit. Page Department Important: It any injury o	6	21 Signaturi of Funeral Service Licensee	Page 22. Name and Address of Facility Hub 4107 Wilkens Avenue	bard Funeral , Baltimore,	
п			23a. Pan1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	andismyor	rams	0,,00, 0,00
	/Medical Examiner		Due to (or as a consequence of):	Cardiomyox	farlar di	near year
9-	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Due to (or as a consequence of):			
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687	icate physi s the t	dice	d			
Box (n certific anding p use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d	. Date of delivery
O. B.	The law requires that the death certificate be executed to has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?	B Ectopic pregnancy Other (specify)		Month Day Year
s, P.O	es that igned by be deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		contribute to the cause of death?
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		Completed	V		24a. Was an 2 autopsy performed? 1 Yes 2 No	4b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
/ita	Physician: Trus certificel ral director, p	Be (25. Was case referred to medical examiner?	26. Place of Death	Check only one)	
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no	ding Afte fune	tlon	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury		od. Describe now injury of	actined.
Division	i or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	8f. Location (Street and N City or Town, State)	umber or Rural Route Number,
_	To the Hospital or At within 24 hours after of To the Funaral Direct completely filled in by	edical Co	29a. Certifier (Check only one) 1□ Certifying Physician: To the best of my knowledge, de 2□ Medical Examiner: On the basis of examination and/or and manner stated.			
	outhin of the comple	Med	29b. Signature and title of certifier	29c. License number		igned (Month, Day, Year)
	C > F 0		De Rangarare MD	D54288	Sen	+ 2nd 06
	20		30. Name and address of person who completed cause of death (Item 23a) (Typ	D54288 Pripi) Northwest	t toppilal	Conte
	Sta Registi		31. Date filed (Month, Day, Year) SEP 0 6 2006 32. Registrar's Signature	Goardi		

ype or Print in Black Indelible Ink. En All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 28048 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1053 P.M homas 03 2006 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Center Baltimore Medica If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 1**X**) M 2□ F Months 216-62-1020 54 Yrs Director June 11, Maryland Usual Residence of Decedent the Maryland r 28a-f show 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits MD n/a Baltimore Yes 2 No Director 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? r than "natural", or iteme 23a or the Medical Examiner must be a 741 Harvey Street 21230 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Caucasian δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 years Business Manager Lockheed Martin ulth and Mental Hygie 27 Is marked other! rraumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil Iment of Health and Mental H tant: If item 27 le marked otl Be John Charles Kehs Marie Dolores Kane ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 741 Harvey Street, Baltimore, MD Nancy Kehs, wife or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Parkwood Cemetery Sept 7, 2006 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 21. Signature of Funeral Service Licenses 6415 Belair Road, Baltimore, MD 21206 N 23a. Part1. Enter the disease of compart failure. List only nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Myruc ardia hou /Medical Due to or as a consequence of) Examiner abetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physicien and the burial-transit evated Due to (or as a consequence of) Physician/Medical obesit use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Į in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 4 Unknown After this certificete has been si tuneral director, page 2 should I 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or within 24 hours after death.
To the Funeral Director: Aft investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of pertition 29c. License number 29d. Date signed (Month, Day, Year) 040363 and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name timente Mera 32 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 6 2006 Registrar

		1 - State Registrar	State of Marylan	d / Department of Certificate			giene 2006 Reg. No.	28049
Phys /Me	ician dical	Decedent's Name (First, Middle, Last) MARY L. KNAUFF				2. Date of Dea	Day Year	3. Time of Death
Funer, Directo	niner	Usual Residence of Decedent	ALE 1405 P M 2 X F 7. Age (In yrs. 1	ast birthday) Yrs. Record Rec	wn, or Location of Death Control Year If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day April /		thplace (State or Foreign arry)
Marylar a-f ehow	tor	Maryland Baltimore		Baltimore Co	ounty			10d. Inside City Limits 1 ☐ Yes 2 No
ath with the	Funeral Director	10e. Street and Number 8812 Philadelphia	Rd.	10f. Zip Co	21237		10g. Citizen of What Co USA	untry?
ore, Maryland 21215-0036 is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. In marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be invitiled at	<u>ک</u>	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	S. 13. Was Deceden If Yes, specify	t of Hispanic Origin? (St Cuban, Mexican, Puerto No <i>Specify:</i>	pecify Yes or No- Rican, etc.)		
1215-C within 72 h ene.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Decedent's Usual C (Give kind of work of life. DO NOT use i	Occupation done during most of wor retired)	king	16b. Kind of Business	Industry
1213 1213 1919 wit 1939 en ther tha	Com	12 yrs. 17. Father's Name (First, Middle, Last)	N/A	Merchand	ise Receive		Sears Roeb	uck & Co.
Advised Temperature of the Market of the Mind Market of the Mind I Market of the Transformatic event, the Market of the Mind I	To Be	Morris E. Ferandes	3		Mabel		Maiden Sumame)	
Maryland and 2 should be file saith and Mental Hy n 27 le marked oth set traumatic event		19a Informant's Name/Relationship (Type Kathy L. Gintling		19b. Mailing Address (S 412 Old Hor	treet and Number or Ru ne Rd. Balt			Zip Code) 1206
Baltimore, Mispermit. Pages 1 and 2 Department of Health a Important: If Item 27 if any injury or other tra		20a. Method of Disposition (★ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)		ace of Disposition (Name ametery, crematory or other on Ch. Cemete		Date 06 E	20c. Location - City or altimore, [
Balti permit. Departin Importe		21. Signature of Funeral Service License	ho Chooc	Lassahi 7401 B	n Funeral H elair Rd. B	ome altimore	e. Md. 2123	6
		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death cause on each line.					Approximate Interval Between Onset and Death
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68760, ificate be executed physicien and as the burial-transii	edicai Exan	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):	east	canc	er	
Box 6 inth certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 N No 9 Unknown	c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ectopic pregr			23d. Date of deli Month	very Day Year
Cords, P.O. Wrequires that the de been signed by the s should be detached	۾	Part II. Other significant conditions cont	nbuting to death but not resu	lting in the underlying caus	e given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
al Record : The law requals cate has been	Completed					24a. Was a autops perform	ned? prior to death?	topsy findings available completion of cause of
'Vital F reician: Th s certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes	spital:	ER/Outpatient 3□ DOA	26. Place of Deat		ence 6 Other (Spec	
ision of trending Physical death.	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 +		Injury at Work?		ow injury occurred	ity)
Divis al or Atte al or Atte s after de if Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hos building, etc. (Specify,	me, farm, street, factory, of	fice	28f. Location (Si City or Town	reet and Number or Ru n, State)	ral Route Number,
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of my know or: On the basis of examinati and manner stated.	vledge, death occurred at the on and/or investigation, in	he time, date and place, my opinion, death occur	and due to the cared at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
To th withir To th	Me	29b. Signature and title of certifier		29c. Li	cense number		9d. Date signed (Month	n, Day, Year)
6		30. Name and address of person who com	npleted cause of death (Item	23a) (Type, Print)	0 170	0	1/31/	Ö
S Regis	tate trar	31. Date filed (Month, 'Oay, Year) SEP 0 6 200	32. Hagistrar's Signati	K Spell	Square Dr	THE BOLL	Linoie, M	D.21237
DHMH 17 Rev 1	/2001			- James				

ORIGINAL

				1 - For State Registrar		f Marylar		artment of H rtificate of L			Reg. No.	006	28050
_	Ţ.	Physici /Medic		1. Decedent's Name (First, Middle, I NATHAN E.V. H						2. Date of D. Month	Day	Year 06	3. Time of Death 22:05PM
		Examir		4a. Facility Name (If not institution, g	H MAT	OSPIT			TIMOR	E		N/A	
		Funeral Director		210-02-11/0	Sex ¥☐M 2☐F	7. Age (In yrs.	(ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bi (Month, D	1956	9. Births MAR	place (State or Foreign ntry) YLAND
		death with the Maryland ime 23a or 28a-f ehow ir novel be notified at	ō	Usuat Residence of Decedent 10a. State 10b. County MD • N/A			ity, Town or Lo					1	10d. Inside City Limits
	1	i or 28a-1	Director	10e. Street and Number	A 77.77	Б	ALTIMO	10f. Zip Code				of What Coul	
5		death w		3709 ECODALE 11. Marital Status	12. Was Dece	edent Ever in U	J.S. 13.	2120 Was Decedent of Hi If Yes, specify Cuba		pecify Yes or N	US 0- 14.	Race - Americ	
L	9600	ours after irai', or ite Examina	Be Completed by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Fo 1 Tes If Yes, Giv Year or D	2 XNo		If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	n, Mexican, Puer Specify:	to Rican, etc.)		Black, White, pecify: BL	etc. ACK
111	Maryland 21215-0036	ithin 72 h ne. han "natu e Mulical	mpietec	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	completed) College (1	-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	turing most of wa	rking		of Business/In	•
Vathan	1d 21	e filed wat Hygier other the	Se Cor	-12- 17. Father's Name (First, Middle, La.			LAB	ORER	18. Mother's Na	me (First, Middle		(GSHORE)	MAN
197	rylar	hould by d Menta marked matic ev	ToE	ELMER V . KEYS			10h Maili	na Addraga (Street		NORE B.			0.41
4	e, Ma	1 and 2 s fealth an om 27 le i		YVONNE KEYS (V		205	370	ng Address (Street as 9 ECODALE position (Name of			MARY	LAND 2	1206
	Baltimore,	Pages nent of H int: If ite iry or of		1 Burial 2 XCremation 3 4 Donation 5 Other (Spec	city)	State	cemetery, crei	matory or other place	. !	2006		ion - City or To	MARYLAND
MD. N/A 10e. Street and Number 3709 ECODALE AVE. 11. Marital Status 12. Was Decedent E. Armed Forces? 13. Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16. ELMER V. KEYS 17. Father's Name (First, Middle, Last) 18. Informant's Name/Relationship (Type, Print) YVONNE KEYS (WIFE) 20a. Method of Disposition 1 Burial 2 (Acremation 3 Removal from State) 10b. County MD. N/A 10e. Street and Number 3709 ECODALE AVE 11. Marital Status 1 N/A 10e. Street and Number 3709 ECODALE AVE 11. Marital Status 1 N/A 10e. Street and Number 3709 ECODALE AVE 11. Marital Status 1 N/A 1 N/A 1 Never Married 2 Married 1 N/Bes 2 Name (Fives, Give A Name) 1 N/Bes 2 Name (Fives, Middle, Last) 1 N/A 10e. Street and Number 3 Wildowed 4 Divorced 1 N/Bes 2 Name (Fives, Middle, Last) 1 N/A 2 N/A 10e. Street and Number 3 Wildowed 4 Divorced 1 N/Bes 2 Name (Fives, Middle, Last) 1 N/A 2 N/A 1 N/A 1 N/A 1 Never Married 2 Married 1 N/Bes 2 Name (Fives, Middle, Last) 2 N/A 2 N/A 3 N/A 4							HIBNER	2. Name and Addres	ss of Facility PH	ILLIPS	FUNERA	L HOME	
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	8760,	cate be executed physician and the burial-transity	i Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):						
		rtificate I ng physi as the b	Aedica		d								
	Division of Vital Records, P.O. Box 6	Attending Physicien: The law requires that the death certific rideath ar death ar death ar death sector. After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		irth 2 ☐ Feta ant at time of c	aldeath 3	Ectopic pregnancy Other (specify)	and sold of		23d	. Date of delive Month	ery Day Year
	rds, P	quires that it in signed by uld be detac	by	Part II. Other significant conditions HIV- AID	contributing to de	eath but not res	sulting in the u	nderlying cause give	en in Part I.		tobacco use		he cause of death?
	Seco.	e law requir has been si e 2 should	Completed	HEPATITI						24a. Was	psy	prior to cor	opsy findings available impletion of cause of
	RENAL INSUFFICIENCY Performed? 1 Yes 12 No 26. Place of Death (Check only one)								death?	2 No			
	of Vi	hysici his cer il direc	To Be	examiner?			ER/Outpatier		er: 4 🗆 Nursing H	lome 5 Res		Other (Specify	y)
	ion	nding P ith: : After t s funera	atlon:	27. Manner of Death 11 Natural 5 Pending 2 Accident investigati		of Injury h, Day Year)	28b. Time of Injury	Work	at (? Yes 2 □ No	28d. Describe	how intury or	ocurred	
	Divis	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	3 Suicide 6 Could not determine	d 288. Place	of Injury - At h	ome, farm, str	reet, factory, office		28f. Location (City or To	Street and N wn, State)	umber or Rura	al Route Number.
	2007	Hospil 24 hour Funer stely fills	edical	29a. Certifier Certifying F	Physician: To the ammer: On the ba and mann	isis of examina	owledge, death	h occurred at the tim vestigation, in my op	e, date and place pinion, death occu	, and due to the irred at the time,	cause(s) and date and pla	d manner as stace, and due to	tated. o the cause(s)
	1	To the To the Comple	Me	29b. Signature and title of certifier			- 00	29c. License	number		29d. Date s	gned (Month,	Day, Year)
		^		· cuple o		U GUP		162	000		09	101	06
		3		30. Name and address of person wh DR RENU GUPTA	completed caus	of death (Iter	RITAN	Print) U HOSPI	TAL, SOO	1 LOCH	KHUEIN	MD	2123.9
		Sta Registr		31. Date filed (Month, Day, Year)	32. R	egister's Signa	ature	boarde					~~~~

State of Maryland / Department of Health and Mental Hygiene 006 2805 L 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SEPTEMBER GERARD BRUCE LOOMIS 04,2006 3:43P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** XXM 2 F 217-50-1523 52 Director 3,1953 Nov. Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location *how 10d. fnside City Limits r than "natural", or Items 23s or 28s-1 shov the Madical Examiner must be notified at Maryland Baltimore Baltimore County 1 Yes XX No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 14 Days End Court 21237 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status ☐Yes 2XNo 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: Specify 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 yrs. al Hygiene. College (1-4or 5+) George Weston Bakery Route Owner permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 Is marked othe sry injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Emerson Loomis Delores Theresa Granese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Days End Ct. Baltimore, Md. 21237 Ramona J. Loomis (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer Cem. 9-8-06 Baltimore City, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimroe, Md. 21236 21. Signature of Euneral Service Licensee Jassals 23a. Part1. Enter the disease, or compfications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PULMONARY EMBOLUS HOUR /Medical Due to (or as a consequence of) Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit LOWER MOTOR NEURON DISEASE 2+ YEARS Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) ed by the a detached f o. 9 Unknown م Part fl. Other significent conditions contributing to death but not resulting in the underlying cause given in Part l. 23e. Did tobacco use contribute to the cause of death? Records, 2 X No 3 ☐ Probably 4 ☐ Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed 200 Division of Vital 1 Tes 2 No 1 🗌 Yes director. 25. Was case referred to medical 26. Place of Death | Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Tyes Certification: To 1 Inpatient 2 X ER/Outpatient 3 DOA funeral 27. Manner of Peath

1 Natural

2 Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely (Check only one) To the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 2006 D 0018662 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 761 WILLIAM GOLDINER, 7601 OSLER TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) SEP 0 6 2006 State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene For Stete Registre 28052 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day MAGDALEN MARGARET LUCAS September 4,2006 3:00 a.™ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11 Jackson Manor Court Phoenix Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 4,1915 **Funeral** Days Hours 1 □ M 2√2 F 215-07-0474 91 **Director** Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Madical Examiner must be notified at Maryland Baltimore Phoenix 1 Yes 2 No Directo 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Itams 23a 11 Jackson Manor Court 21131 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene important: If Item 27 is marked other than "natural", or Itams 23a eny highry or other traumatic event, the Madical Exemples proces. U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kasinskas Joseph Catherine Zardeskas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Nancy L. Heyl (Daughter) 11 Jackson Manor Court Phoenix, Maryland 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 9-8-06 St. John Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Hydes Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 6500 York Road Baltimore, Md. 21212 23a. Part1. Enter the disease, or complications traticaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Congestive heart failure Years /Medical Due to (or as a consequence of): Examiner Infero-lateral myocardial infarction 10-20 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Atherosclerotic Heart Disease Years attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical ğ IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown X 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached i 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Aortic valve stenosis 3 Probably 4 Unknown Was an autopsy performed? Cerebrovascular accident (June 10, 2000) 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Chronic renal failure certificate 1 Yes 25. Was case referred to medical examiner?
1 Types 2 M No To Be 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home Fig. Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA s after deau.. rel Director: After th 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide within 24 hours a To the Funerel C To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number D0022633 29d. Date signed (Month, Day, Year) September 5, 2006 29b. Signation and title of certifier and I dress of person who completed cause of death (Item 23a) (Type, Print) Jorge Secada-Lovio, MD 7401 Osler Drive Towson, Maryland 21204 32 Aegistrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 6 2006 Registrar

			State of Maryland / Department of He State of Maryland / Department of He Registrar Certificate of D	ealth and Me Death		ene 2006	28053
	Physici		1. Decedent's Name (First, Middle, Last) Louise McDowell	2	2. Date of Death Month	Day 2 Year 2006	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or L	Location of Death	ity	4c. County of Death	
	Funeral Director		212-28-9177 1 M 2 OXF 72 Yrs. Months Days	Hours Min.	3. Date of Birth (Month, Day, 1 09/23/19		place (State or Foreign htry) Carolina
51	Maryland f show	ō	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Baltimore			1	0d. Inside City Limits
ma(vith the Ma t or 28a-f a	Direct	10e. Street and Number 10f. Zip Code	_	100	g. Citizen of What Cour	itry?
Louise Mc Dowel	hours after death with the Maryland lural', or iteme 23a or 28a-f show at Examinar must be notified at	by Funeral Director	4502 Garrison Boulevard 11. Marital Status 1 □ Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 M No		ify Yes or No- ican, etc.)	U.S.A. 14. Race - Americ Black, White,	
25.00-		ed by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No 15. Decedent's Education 16a. Decedent's Usual Occupation	Specify:	16	Specify: Bla	
Lo1	i within 72 jiene. r than "nai	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+)	uring most of working	7	Housekeepi	·
AS:	be filectal Hyg	Be		18. Mother's Name (First, Middle, Ma		0
ກາຍພາ e, Maryl	d 2 should th and Men 7 is marke treumatic	ဥ	19a. Informant's Name/Relationship (Type, Print) Minnie Brown / Daughter 19b. Mailing Address (Street and 4502 Garrison I				
ore,	iges 1 and of Healt if Itam 2 or other		20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place)	Dar	te 20	Oc. Location - City or To	own, State
Tent Known As: Louise, Baltimore, Maryland 21215-0036	permit. Pag Department Important: i any injury o		4 □ Donation 5 □ Other (Specify) Loudon Park Cemeter 21. Signature of Funeral Service Licensee 22. Name and Address 4611 Park H	s of Facility The	Derrick		/H, P.A.
8760, /g	Physician /Medical Examiner / (Lie prival-transit p	dical Examiner	23a. Part1. Enter the disease, or complications that has sed the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Oue to (or as a consequence of): Oue to (or as a consequence of):	g, such as cardiac or i	respiratory arres	st,	Approximate Interval Between Onset and Death
Box 6	Attending Physicien: The law requires that the death certifics rolesth. cleath. ector: After this certificate has been signed by the attending pt by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 1 Ves 2 No 9 Ves No No No No No No No N			23d. Date of delive Month	ery Day Year
ds, P	uires that signed by Id be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given DM I micrount anemic	n in Part I.		cco use contribute to the	ne cause of death?
Division of Vital Records, P.O.	: The faw requir cate has been si . page 2 should I	Completed by	HTN recurrent UTI'S		24a. Was an autopsy performs	24b. Were auto prior to cool death?	psy findings available impletion of cause of
Vita	ysician: ils certific director.	To Be (25. as case referred to medical examiner? 1 Yes 2 No Hospital: 1 I patient 2 ER/Outpatient 3 DOA Others	26. Place of Death (ce 6 Other (Specific	iv)
ion of	nding Phy tth. r: After thi	ation: T	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury a 1-1 Natural 5 Pending (Month, Day Year) Injury Work?		d. Describe how		,
Divis	To the Hospitel or Attendi within 24 hours after death. To the Funaret Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	8f. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,
	• Hospitel or 124 hours afte • Funaret Dir tetely filled in I	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.	e, date and place, an inion, death occurred	nd due to the cau d at the time, dat	ise(s) and manner as si e and place, and due to	ated. the cause(s)
	To the within 2 To the complete	Me	29b. Signature and ville of Contribution 29c. License of R (S	number 000	290	Deut DZ	Day, Year)
	8		30. Na found dd s of person who complited cause of death (Item 23a) (Type, Print)	vi Hos	pital	of Ra	Itim mis-
	Sta Regista		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene 2006

			1 - For State Registrar	State of Mary	land / Dep	artment of his	lealth and M	Mental Hygie	ne 20 06	28054
	Physici	an	1. Decedent's Name (First, Middle, Last,)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	cal	John B. Morrell 4a. Facility Name (If not institution, give	atract and autobas)		4h Cibi Taura	or Location of Death	Aug. 31,	2006	1:55 P ^M
	Examir	ier	9443 Ashlyn Circle	·		,			4c. County of Deat	
	Funeral		5. Social Security Number 6. Sec	x 7. Age (In	yrs. last birthday,	Owings If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Baltimor	e hplace (State or Foreign untry)
	Director		005-24-3371	M 2□F -	76 Yrs.	Worthis Days	TIOUIS NAME.	8. Date of Birth (Month, Day, Ye Sep. 12,	1929 Mai	ne
	ow ow		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limits
	a-f sh	ctor	MD Baltimor	e	Owings	Mills				1 ☐ Yes 2 🙀 No
	ith th	Funeral Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?
	eath v	erai	9443 Ashlyn Circl	.e 12. Was Decedent Ever	in IIS 12	21117	dispania Origina (Sp	acity Vas or No-	USA 14. Race - Ame	rican Indian
ເດ	r Item	Fun	11. Marital Status 1 ☐ Never Married 2 Married	Armed Forces? 12 Yes 2 ☐ No			dispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, White	
ğ	iral', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	Marine	1 ☐ Yes 2 ☐ XNo	Specity: whi	te	Specify: W	hite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23e or 28e-f show he Medical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ing 16b	. Kind of Business/	Industry
212	d within	ошр	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		national	•	1	Banking	
힏	be filed ital Hygir d other event, II	BeC	17. Father's Name (First, Middle, Last)					e (First, Middle, Maid		
ya	Ment Ment Marked Marked	T _o	Malcolm E. Morrel				Edna B			
Maryland	d 2 st th and traun		19a. Informant's Name/Relationship (Ty Lynn T. Morrell -					al Route Number, Ci	NOTES CHILDREN	1000
ē,	of Health fitem 27 rother te		20a. Method of Disposition	2	Ob. Place of Dispe	osition (Name of matory or other place		ings Mills Date 200	Location - City or	Town, State
<u><u>E</u></u>	Pages nent of I ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Metro Cr	ematory	Sep.	6, 06 Ba	ltimore.	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: If item 27 is marked other than "naturat", or iteme 23a or 28a-f show any rightry or other traumatic event, the Medical Examinar must be notified at ODGs.		21. Signature of Funeral Service Licen	600	ζ.	2. Name and Addre	ss of Facility Society	f Marylar Baltimore	id. Inc.	20
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused the	death. Do not en	ter the mode of dvir	TCK ROAG	Baltimore	e, MD 2122	Approximate
	Physician		Immediate Cause (Final							Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	Due to (or as a co	nsequence of):	- Usig	cance	-r		25 months
ч	Examiner		Sequentially list conditions,	Emphu Due to (o' as a	sema					In the
	ted nsit	Examiner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o Diver						1 4
o,	te be executed ysicien and e burial-transit		that initiated events resulting in death) Last	Due to (or as a co		1				1 / 19
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89 ×	ding p	by Physician/Med	IF FEMALE:	23c. If yes, outcome of pr	regnancy				2012 115	
.O. Box	death dath d for u	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	<i>'</i>		23d. Date of deli	very Day Year
<u>О</u>	at the by the staches	hys	9 ☐ Unknown	9□ Unknown						
S,	The law requires that the death certifica ste hes been signed by the attending ph page 2 should be detached for use as th		Part II. Other significant conditions cor	ntributing to death but no	t resulting in the u	inderlying cause giv	en in Part I.			the cause of death?
Records,	v requ	Completed						24a. Was an		
æ	The lav	dmo						autopsy performed	? prior to c death?	topsy findings available ompletion of cause of
Division of Vital	ician: Th certificete ector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Deat	1 ☐ Yes 2 ☐ 1 (Check only one)	No I Tes	2 1 No
o , <	Physic this ce al dire	၉	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie		4 🗆 Nursing no	me 5 Mesidence		ufy)
on	Attending Physician: r death. sctor: After this certifice by the funeral director, p	tion:	27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o	Wor	y at k? Yes 2 □ No	28d. Describe how in	njury occurred	
Visi	Atter r dea ector by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury	At home, farm, st			28f. Location (Street		ral Route Number,
ā	Hospital or Attendes to the foursafter deatler funeral Director: tely filled in by the			building, etc. (S				City or Town, St	·	
	To the Hospital or Attenswithin 24 hours after deatl To the Funeral Director:	Medical	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my ner: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	h occurred at the tire to the	me, date and place, pinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	and marrier stated.		29c. Licens	e number	29d.	Date signed (Month	, Dey, Year)
ł	7		1	M.O.		13-	11653	0	9/05/	2006
	10		30. Name and address of person who co	ompleted cause of death		Print)	- 1 11	Baltimon		
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's S	Signature -	reene	st. K	oa Itomob	ema	2/201
	Registr		SEP 0 6 200	6 Hours	Signature Ap	and s				

				For State Registrar	State o	f Mary	/land / Depa <i>Ce</i>	artmen rtificate				lental Hy		006	28055
		Dhucici	an	1. Decedent's Name (First, Midd	e, Last)							2. Date of De Month	D	Year	3. Time of Death
		Physici /Medio		Carolyn M. Ma								Sep. 3	3, 200		9:25 A M
		Examir	er	4a. Facility Name (If not institution		nber)				Location of	of Death		4c. C	ounty of Dea	
				Spa Creek Cen 5. Social Security Number	ter 6. Sex	7 Age (Ir	n yrs. last birthday)		apol	IS If Under	24 Hrs.	8 Date of Bir		e Aru	ndeL
		Funeral Director		218-32-3774	1□M 2∰F		84 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da July 2	Year 19	22 s	outh Carolina
				Usual Residence of Decedent				1				1	, , ,		
		irylan ihow	_	10a. State 10b. County		10	Oc. City, Town or Lo	ocation							10d. Inside City Limits 1 □ Yes 2 🛱 No
		Ba-fa	cto		Arundel		Annapolis								
		death with the Marylan ome 23a or 28a-f show ir must be notified at	100	10e. Street and Number				10f. Zip						on of What C	ountry?
		eath ve 23s	E S	605 Ridge Dri	VE 12. Was Dec	adopt Evo	rin II S 12	214		spanio Ori	gin? (Sp	acity Vac or N	US		encan Indian,
		ther d	Funeral Director	1 ☐ Never Married 2 ☐ Mar	Armed Fo	rces?						ecify Yes or No Rican, etc.)	. .	Black, Whi	
2	93	ours aff	by	3 Widowed 4 □ Divorce	It Yes, Gir Year or D	re ates:		1 ☐ Yes	2 <mark>∭</mark> No	Specify:		ite	S	pecify:	white
3	5-0036	72 hours after "natural", or It	eted		it's Education st grade completed)		16a. Dece	dent's Usua kind of woi	I Occupa	ation fu <i>rina m</i> os	t of work	ina	16b. Kind	of Business	s/Industry
35	2121	hen .	Ig m	Etementary/Secondary (0-12)	College (-4or 5+)	life.	DO NOT us	se retired,)		3	- 1	-	
N	2	filed within 72 hours after death with the Maryland I Hygiene. other than "natural", or Items 23s or 28s-f show rent, the Medical Exemilier must be notified at	Be Completed	12 17. Father's Name (First, Middle,	/ast)		Nurs	se		18 Mothe	ar's Name	e (First, Middle		pender	nt
5	and	d be f ental l	To Be	Robert M. Mann	2007							Grant	, maidon o	amamo,	
	Mary	s 1 and 2 should be filed within f Heelih and Merial Hygiene. Itsm 27 is marked other than other traumatic event, the M	F	19a. Informant's Name/Relation:	ship (Type, Print)		19b. Maili	ng Address	(Street a			al Route Numb	er, City or	Town, State,	Zip Code)
0		and 2 eelth a n 27 ls		Joseph F. Mar	tin, Jr	son	605 I	Rid e	Driv	e An	napo	lis, M	2140	3	
9/3/0	ore	es 1 and 2 of Heelth f Itsm 27 I		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 Demoval from		20b. Place of Dispo cemetery, cre-	osition (Nan matory or o	ne of ther place	9)	- 1	Date	20c. Loca	ation - City o	r Town, State
6	Ë	Pages ment of I ant: If Its ury or o		4 Donation 5 Other (S			Metro Cre					6,06			
	Baltimore,	permit. Pages Depertment of Himportant: If Its eny Injury or of page.		21. Signature of Funeral Service	Licentee	Ma	el 2	2 Name an Cremat	d Addres	Societies of Societies	ety Road	of Mary Baltin	land,	Inc.	228
2				23a. Part . Enter the disease, o shock, or heart failure. Lis	r comptications that of	aused the	death. Do not en	ter the mod	e of dying	g, such as	cardiac	or respiratory a	rrest,	111/ 21	Approximate Interval Between
		Physician /Medical		tmmediate Cause (Final disease or condition resulting in death)	a. De	riby	end view	uln	112	une	Fr	right	وع		Onset and Death
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		ite be executed lysicien and he burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	С										
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7	8760	physic the b	dical		d								_		
4	9 x	eath certifice attending pt for use as t	/Me	IF FEMALE:	23c. If yes, ou	come of p	pregnancy						27	d. Date of de	divor
7.	B	death atter	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🕱 No	1 ☐ Live t	irth 2	Fetal death 3	Ectopic production of the control of					20	Month	Day Year
2	0	thet the de ed by the detached	hys	9 ☐ Unknown	9□ Unkn	own		-							
	S, P	The law requires thet the death certificate be executed site hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	by Physician/Med	Part II. Other significant conditi	ons contributing to d	eath but n	ot resulting in the u	nderlying c	ause give	n in Part I.		23e. Did	tobacco use		o the cause of death?
2	ord	w require been si should b										1 🗆	Yes 2□	No 3□P	robabiy 4 Dunknown
1	ecc	e taw r hes be je 2 sh	Completed									24a. Was	an psy	24b. Were a	utopsy findings available completion of cause of
>	E	: The t										perfo	2 No	death? 1 ☐ Ye	s 2 No
2	Vita Vita	ilclan: Th certificete rector, pag	Be	25. Was case referred to medica examiner?	Hospital:				Othe	_ /		h Check only			
0	j o	Phys r this ral dii	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	10		2 ER/Outpatie		'A	4 💌 INU		me 5 Resi			ecify)
7	on	Attending Physician: r death. sctor: After this certifics by the funeral director. I	tlon	1 Natural 5 ☐ Pendi	28a. Date ing (Mon gation	th, Day Ye	ear) Injury	м	8c. Injury Work 1 ☐ \	:?` ∕es 2 🔲					
0	Division	or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	not be 28e. Place	of Injury	- At home, tarm, st Specify)	reet, factory	, office				Street and wn, State)	Number or F	Rural Route Number,
	L.	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	al Ce	29a. Certifier 1 Certifyi	ng Physician: To the	best of m	ny knowledge, deat	h occurred	at the tim	e, date an	d place	and due to the	cause(s) a	nd manner a	s stated.
		he Ho in 24 h he Fu pletely	Medical	(Check only 2 Medical one)	Examiner: On the b	asis of exa ner stated	amination and/or in	vestigation,	, in my op	oinion, dea	th occur	red at the time,	date and p	lace, and du	e to the cause(s)
		To the within 2 To the complet	Σ	29b. Signature and title of certifi	or a	1		290	License	327	2 :			signed (Mon	th, Day, Year)
	•	1		Pyly 1 X	money	ハノ			V		20		1'	- 10	000
		10		30. Name and address of per											
		Sta	te	Gary J. Sprous 31. Date tited (Month, Lay, Year	32 F	S Dir legistrar's	Oonato Dr Signature	ive C	hest	er, M	D 21	619			
		Registr		SEP 0 6	2006	Eph Bud	Signature								8

06-06590 Joe

Please Type or Print in Black Indelible Ink

Joey D. Murphy		1- For State Registrar		te of Maryland	-	rtment of tificate of		nd Me	ental H	-	Reg. No.	200	6 280
Physici Medical Exam		1. Decedent's Nam		Daniel Mu	rphy	У				2. Date of De Month Septemb	Day	Vear	3. Time of Death 0731 hrs
		4a Facility Name (117 Robinh		, give street and number)		4	b. City, Town, Havre de		on of Death		1	County of Deatl arford	n
Funeral Director		5 Social Security (219-08-9)	539	5. Sex 7. Ag		ast birthday) 21 Yrs.			Inder 24Hrs ours Min		,	Foreig	rthplace (State or gn ^{puntry)} Mary lan
any		Usual Residence of 10a. State	f Decedent 10b. County		10c. City,	Town or Locati	on						10d Inside City Limit
Maryland 28a-f show	tor	MD		rford			Havre	De_	Grace				1 Yes 2 XN
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Nu		: II 1 D	1		10f. Zip Code	24.07	_		10g Citiz	en of What Cou	ntry?
nore, MD 21215-0036 ages: I and 2 should be filed within 72 hours after death with the Maryland nt of Heath and Mantel Hygiene. If Iftem 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once		11. Marital Status		in Hood Road	Ever in U.		s Decedent of I		Origin? (Sp		0- ′		ican Indian, Black,
er death , or iter	Funeral	1 X Never Marri 3 Widowed		1 X Yes 2	No No		es, specify Cub			Rican, etc.)		White, etc.	hite
ours afte ntural"	d by			rced If Yes, Give Year 200 or Dates: fy only highest grade com		16a. Decedent		ation (G	ive kind of v			Specify: Wind of Business/	
36 n 72 hc nan "nz ical Ex	Completed	Elementary/Sec	ondary (0-12)	College (1-4 or	5+)	during mo	ost of working li	te. DO N	IOT use reti	red)		.	_
5-00; ed withi ygiene yther th	Com	12 17. Father's Name	(First, Middle, I	.ast)			Clerk	18. M ot	ther's Name	(First, Middle,		Rite Aid Surname)	<u>d</u>
21215-0036 uld be filed within 7 Mental Hygiene marked other than	Be		Dean Mu	<u> </u>					Robin	n Adkin	S		
MD 2 d 2 should lth and M n 27 is m aumatic	2	19a. Informant's Na Denise Ma					Old Rok					y or Town, State De Grae	e, Zip Code 21078
more, N Pages I and Ient of Health ant: If item	13	20a. Method of Dis	position	3 Removal from Sta		Place of Disposi crematory or oth	ition (Name of			Date		ocation - City or	
E 4 5 8 7		4 Donation 5	Other Spe	ecify:	_ I	ro Crem				5/06		ltimore	
Balti permit Departn Imports		21. Signature of Fu	ineral Service L	me			ame and Addre		Cre			iety of • MD 21	MD, Inc.
Physician		23a. Part I. Enter th		omplications that caused	the death	. Do not enter th	ne mode of dyin	g, such a	as cardiac o	r respiratory a	rest, sho	ck, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause or condition resulti		a Multiple Injuries		£/·							Death
		Sequentially list co	onditions,	b									
	Examiner	if any, leading to in cause. Enter Under (Disease or injury	erlying Cause	Due to (or as a conse	equence o	f):							
cecuted 1 and - transit	Exar	events resulting in		Due to (or as a conse	equence o	f):		-					
50, te be execu ysician and	Medical	UNPENDED		AMENDED									
اه کے ح	/Me	IF FEMALE: 23b. Was decedent	pregnant in the	23c. If yes, outcor	ne of preg		tel dente 3	B Ect	opic pregna			Date of deliver	
Box 687 e death certific the attending p	Physician/	past 12 months	s?	4 Pregnant at	time of de	ath	tal death S ner (Specify)) []Ed	opic pregna	iricy	1	Month i	Day Year
cords, P.O. Box 687 aw requires that the death certifications been signed by the attending p 2 should be detached for use as the	Phys			ons contributing to deat	h but not r	esulting in the u	nderlying cause	e given ir	n Part I.	23e. Did	tobacco u	ise contribute to	the cause of death?
, P.O.	d by									1 Y	es 2 🗸	No 3 Pro	bably 4 Unknown
Division of Vital Records, tall or Attending Physician: The law requires and arder death. The property of the this certificate has been simple from the funeral director, page 2 should to but the funeral director, page 2 should to but the funeral director.	Completed									24a. Was auto	psy	prior to	utopsy findings available completion of cause of
tal Rec rian: The la certificate h	Com									1 🗸 Yes	ormed? 2 No	death?	es 2 No
Vital hysician: this certiff	æ	25. Was case reference examiner? 1 ✓ Yes	red to medical	Hospital: 1 Inpatie	ent 2	ER/Outpatient		Other	ath (Check	only one) ng Home 5	Resider	nce 6 🗸 Othe	r: Scene
IVISION Of VI or Attending Physi after death. Director: After this	Certification: To	27. Manner of Dea	th	28a. Date of Inju (Month, Day, Y Sep 3, 2006	iry 'ear)	28b. Time of Ir	njury 28c. Ir	jury at W		28d. Describe		ry occurred	on
Sion Attend r death. ector:	catic	1 Natural 2 Accident	5 Pendi Invest	igation		0726 hrs ome, farm, stree	1_	Yes 2	No				ural Route Number, City
Divi	ertifi	3 Suicide 4 Homicide	6 Could determ	not be			et, ractory, office	s Donairig	g, 6 10.	or Town,	State)		de Grace, MD
e Hospital 24 hours e Funeral		29a. Certifier 1		/sician: To the best of m									
To the Hos within 24 h To the Fur	Medical	one) 2 🗸		niner: On the basis of exa and manner stated.	mination a	ind/or investigat	29c. Lice			at the time, date	-	ce, and due to the	
		ML	sa Bin	sell M	D			C.M.E.				tember 3, 20	
Total .				who completed cause of c									
U ' 1		Melissa Bra 31. Date filed (Mor		Assistant Medical			enn Street,	Baltim	nore, MD	21201			
S Regis	tate trar	C Date med (WO)	FD 0 6		all all	Local Contract	E. S.						

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Marylan	•	artment of H tificate of L		nental Hygi	ene 2006	28057
	Physici		1. Decedent's Name (First, Middle, Last) Dale Allen Mul.	lins				2. Date of Death 0 9 - 0 1 -	Day Year	3. Time of Death 7:00 A M
	/Medic Examin		4a. Fecility Name (If not institution, give s			•	Location of Death		4c. County of Deat	h
	Funeral		1978 Chipper Dr 5. Social Security Number 6. Seg		last birthday)	Edgewood tf Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Harfor 9. Birt	hplace (State or Foreign
	Director		212-40-9200	7. Age (In yrs. 56	Yrs.	Months Days	Hours Min.	8-5-19	50	MD MD
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	the Mar 28a-fs	ector	MD Harford	i E	dgewo	o d		10	og. Citizen of What Co	1 Tyes 2 No
	h with	ai Dir	1978 Chipper Dr	ive		21040	0		USA	
36	72 hours after death with the Maryland natural', or Items 23e or 28e-f show iscal Examinat be notified al	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba t ☐ Yes ※ No	ispanic Origin? (Sr n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
21215-0036	- 39	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give life. l	tent's Usual Occupa kind of work done of DO NOT use retired	during most of wor ()	king	16b. Kind of Business/	Industry
1d 2	iled withir Hygiene. other then	a)	1 2 17. Father's Name (First, Middle, Last)			nsurance		ne (First, Middle, M		irce
Maryland	2 should be and Mental is marked o	ToB	William L. Mul					s Mebus		
	s 1 and 2 should be filed f Health and Mental Hyg Itam 27 is marked othe other traumatic event,		19a. Informant's Name/Relationship (Ty Susan Mullins -						City or Town, State, 2 d MD 21	
Baltimore,	ges 1 and 2 t of Health if itam 27 to or other tre		20a. Method of Disposition 1 Burial 2X Cremation 3 F	20b. F	Place of Dispo emetery, cren	sition (Name of natory or other plac	(8)	Date 2	20c. Location - City or	Town, State
Itim	permit. Pages in Department of Himportent: if its any injury or ot once.		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature → Funeral Service License	Ва		Cremate.			Baltimor	
Ba	Depa impo any id		Dethacket) —	В	radley-	Ashton	F.H. P.	w Spring A.Balti.	Md 21222
П	V Service		23a. Part1. Enter the disease, or complishock, or heart failure. List only or tmmediate Cause (Final	e cause on each line.						Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		disease or condition resulting in death)	Due to (or as a conseq	Jones all	reards	al Is	fari	1	Instinct
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter or barying Cause (Disease or injury	Due to (or as a conseq	uence of):					
	be executed sician and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	cate be exphysician the buria	cai)					<u>-</u>	
O. Box 6	death certific e attending p id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	t death 3	Ectopic pregnancy Other (specify)		<u>.</u>	23d. Date of de Month	ivery Day Year
rds, P	es tha	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did tob	oacco use contribute to	othe cause of death?
Vital Record	The law ate has b page 2 sl	Completed						24a. Was ar autops perform 1 Yes 2	y prior to ned? death?	stopsy findings available completion of cause of 2 No
Vita	Physician: Th this certificate ral director, paç	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	lospital:	ER/Outpatier	nt 3 DOA Oth	00	th (Check only on	e) ence 6 □Other (Spe	city)
ion of	ling After une	H- 1	27. Manner of Death 1 Natural 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time or tnitury	f 28c. Injun Worl	y at		w intury occurred	509)
Division	al or Attend after death Director: d in by the f	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specifical Control of the control of	ome, farm, str	eet, factory, office		28f. Location (Str City or Town	reet and Number or Ri , State)	ural Route Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	edical (sician: To the best of my knowner: On the basis of examination and manner stated.						
	To the within To the Comp	×	29b. Signature and title of certifier	20	- 10	29c. Licens			9d. Date signed (Mont	
•	1		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type,	Print)	12039		00112	2006 VITE107
	7		WALTER R	WELZA	UTH	70	76000	SCEX	DA S	VITE/07
	Sta Regist		31. Date filed (Month, Day, Year) SEP 0 6 20	32. Agistrar's Signa	S. E.	revie				

				For State Registrar	State of Maryla			of Health and No.		giene2 (106	28058
		P 81		Decedent's Name (First, Middle, Last)			•		2. Date of De	ath Day	Year	3. Time of Death
		Physici /Medi		Robert William	Morrison				Septen	ober 2	2006	1336 м
		Examir	ier	4a. Facility Name (If not institution, give str			-	own, or Location of Death			y of Death	
			340	Upper Chesapeake 5. Social Security Number 6. Sex		ter s. last birthday)	If Under 1		B. Date of Bir	Harf	9. Birthp	lace (State or Foreign
		Funeral Director			^{M 2□F} 61	Yrs.	Months	Days Hours Min.	Oct. 1	, 1944 , 1944	Penn	sylvania
		Ø)		Usual Residence of Decedent	NE.	City, Town or Lo						0d. Inside City Limits
		with the Maryland a or 28a-f show be notified at	5	10a. State 10b. County			cation				'	1 ☐ Yes 2X No
0		he M	ecto	Maryland Harford 10e. Street and Number	Be	el Air	10f. Zip (Code		10g. Citizen of	What Cour	ntry?
3		with a or	흐	305 Glenwood Road				014		USA		,
42		death with the Maryland ims 23s or 28s-f show rmust be notified at	Funeral Director		2. Was Decedent Ever in	U.S. 13. V	Vas Decede	ent of Hispanic Origin? (Sp fy Cuban, Mexican, Puerto	pecify Yes or No)- 14. Ra	ce - Americ	
	9	or ite	F	1 ☐ Never Married 2X Married	Armed Forces? 1 XYes 2 No If Yes, Give		r ves, speci I∐ Yes 2		nican, etc.)	Speci	ack, White,	etc.
9	933	ural',	d by	3 Widowed 4 Divorced	Year or Dates:						Wh:	ite
9/2/06	21215-0036	within 72 hours after dea ene. then "natural", or items	Completed	15. Decedent's Educa (Specify only highest grade		(Give	lent's Usual kind of worl DO NOT us	l Occupation k done during most of wor. a retired)	king	16b. Kind of I	dusiness/in	dustry
121	12	withir ene. then	dinc	Elementary/Secondary (0-12)	College (1-4or 5+)			ngineer		U.S.	Gover	nment
0	d 2	Hygi other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle	, Maiden Suma	me)	
	ılan	Aenta Aenta rksd tic sv	ToB	Edward Washington	Morrison S	r.		Blanche	Ellen	Denni	son	
5	Maryland	es 1 and 2 should be filed within 72 hours alter death v of Heelth and Mental Hygiene. I ttem 27 is marked other then "natural", or ftems 23s r other traumatic event, the Medical Examinermust.		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	ng Address	(Street and Number or Ru	ral Route Numb	er, City or Town	n, State, Zip	Code)
354		and and marking markin		Cathie Ann Morriso		305 (ood Road, Be	l Air,	Marylan 20c. Location	d 210	14
43	ore	ges 1 it of H if Ite or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, cren	natory or ot	her place)			,	
34	Baltimore,	t. Pa rtmen rtsnt: njury		4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service License				al Park 9-8-			LVI,	Pennsylvani
800	Bal	permit. Pages : Department of H Important: If Ite any Injury or ot		Stepley a. Me	igh		131/(d Address of Facility AS Funeral H Cokesbury Ro	ad, Abi	ngaon,	Maryla	
X			12	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the de cause on each line.	ath. Do not ent	er the mode	of dying, such as cardiac				Approximate Interval Between Onset and Death
	and the same	Physician		Immediate Cause (Final disease or condition resulting in death)	advances	,	nic	lymphosphic	1-eui	Kemia		2 yrs.
		/Medical Examiner		1630Killig III dozulij	Due to (or as a cons	equence of):						O
			ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence of):						
	11	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
_>	N,	be executed sicien and burial-transit		resulting in death) Last	Due to (or as a cons	equence of):						
0	8760	ate be hysici the bu	cal	d.								
1	9		by Physician/Medical	IF FEMALE:				-				
3	Box	that the death certific ed by the ettending p detached for use as	lan/	23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of prec 1 ☐ Live birth 2 ☐ Fi 4 ☐ Pregnant at time o	etal death 3	Ectopic pro				ate of delive nonth	ery Day Year
30	Ö	he de the c	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	i death 3L] Other (Spr	acity)				
O	٩	that t	4	Part II. Other significant conditions conf	ributing to death but not i	resulting in the u	nderlying ca	ause given in Part I.	23e. Did	tobacco use co	ntribute to t	he cause of death?
X	rds	w requires t been signe should be							1 🗆	Yes 20 No	3 🗌 Prol	bably 4 Unknown
0	\ <u>0</u>	s bee	Completed						24a. Wa	s an 24b	. Were auto	opsy findings available ompletion of cause of
ORGISON	R	en: The lav tificate has tor, page 2	E						per 1 ☐ Yes	ormed?	death?	
2	Vital		BeC	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only	оле)		
N	of <	S S	ျ	1 ☐ Yes 2 No		ER/Outpatier			lome 5 ☐ Res			fy)
N			ino.	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year	28b. Time o Injury	M 2	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occ	urrea	
0	isio	death ctor: /	ertification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	t home, farm, sti			28f. Location	(Street and Nur	nber or Rur	al Route Number,
7	Division	afte d Direc	ert	4 Homicide determined	building, etc. (Spe	ecify)	,	,	City or To	оwn, State)		
		e Hospitel or Intending 24 hours after death. 8 Funeral Director: After letely filled in by the fune	edical C	29a. Certifier 1 Certifying Physic (Check only one)	ician: To the best of my ler: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred vestigation	at the time, date and place, in my opinion, death occu	a, and due to the urred at the time	a cause(s) and a	manner as s e, and due t	stated. to the cause(s)
		To the Hosi within 24 ho To the Func	Med	29b. Signature and title of certifier	and market states.		290	: License number		29d. Date sig	ned (Month,	Day, Year)
		⊬≱⊬ઇ		D .	al -			D54841		9/	3/06	2
		142		30. Name and address wherson who con	mpleted cause of death (Item 23a) (Type,	Print)					
ž.		154,		Ashkan Bahrani				Suite 200, E	el Air.	Maryla	nd 21	014
			ate	31. Date filed (Mohth, "Day, Year)	32. Apgistrar's Si	gnature	-0		·	*		
		Regis	trar	SED 0 6 200	6	50 B	make B					

DHMH 17 Rev 1/2001

ORIGINAL

			For State Ragistrar	State of Ma	aryland	d / Depa <i>Cer</i>	irtment of H <i>tificate of l</i>	ealth and N Death		iene2 0	06	28059
	Dhusisi		1. Decedent's Name (First, Middle, Las	st)					2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medio		Harry Dunnell	Maple					Septemb		2006	8:45 P M
*	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Death		4c. County	of Death	
			Manor Care Healt				Towson		T	Balt:		
į.	Funeral		5. Social Security Number 6. S	ex 7.Age ⊠M2□F		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			lace (State or Foreign try)
b	Director		267-01-6213 Usual Residence of Decedent		85	113.			Aug. 3,	1921	New	Jersey
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	Man)	ţō	Maryland Harfor	đ	Be1	Air						1 ☐ Yes 2 📉 No
	r 28s	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of V	Vhat Coun	try?
	15 with	a D	1705 Jennings D	rive			21019	5		USA		
21215-0036	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or Iteme 23a or 28a-f ehow other than "natural", or Iteme 23a or 28a-f ehow event, I'm Mudical Exarting I intal be mulified at	by Funeral	11. Marital Status 1 □ Never Married 2 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 X Yes 2 □ N If Yes, Give Year or Dates:			Vas Decedent of H i Yes, specify Cuba ☐ Yes 212 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)		e - Americ k, White,	
O	2 hou	ed	15. Decedent's Ed	lucation		16a. Deced	ent's Usual Occup	ation		16b. Kind of Bu		
215	within 73 ene. than "n	Completed	(Specify only highest gra	de completed) College (1-4or 5	<u> </u>	(Give life. L	kind of work done of NOT use retired	during most of wor. ()	king			
21	filed with Hygiene. Ither than	E O	11			Elect	rician			Commerc	cial	
nd	al Hygie d other	Be (17. Father's Name (First, Middle, Last)	_					ne (First, Middle, M		е)	
Maryland	2 should be and Mental le marked o aumatic eve	ဥ		Maple						ecker		
Jar			19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street a	and Number or Ru	ral Route Number,	City or Town,	State, Zip	Code)
	of Health		Botty Maple / Da 20a. Method of Disposition	ughter	20h P	1703	Jennings sition (Name of	Drive, I	el Air,	Marylar 20c. Location	rd 21	015
ŏ			1 □Burial 2 □ Cremation 3 □		CE	emetery, cren	natory or other plac				,	
Baltimore,	nit. Paratmen ortent: injury		4 Donation 5 Other (Specification)		HI	_	Memorial				on, M	aryland
Ba	permit. Pag Department Importent: I eny injury o		21. Signature Funeral Service Licer	Duck			Name and Address CCOMAS Fi 317 Cokes				ryla	nd 21009
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one caúse on each lir	10.	n. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	_	Approximate Interval Between Onset and Death
No.	Physician		Immediate Cause (Final disease or condition	a. Com	plu	catim.	of D	entata				1 Cars
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):						
		_	Sequentially list conditions,	b. Due to (or as	* *****	man all						
Φ.	ted nsit	nin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 43	u 001133qu	adrics or).						
₽	al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as:	a consequ	uence of):						
68760,	ficate be executed physicien and is the burial-transit	edical E		d								
	ificate g phy as the			. u.								
P.O. Box	the Hospital or Attending Physician: The law requires that the death certific in 24 hours after death. The Funerel Director: After this certificate has been signed by the attending p the Funerel Director. After this certificate should be detached for use as implietely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3 [Ectopic pregnancy Other (specify)			23d. Dat Moi	e of delive nth	ry Day Year
rds, P	quires that n signed b uld be deta	ρ	Part II. Other significent conditions of	ontributing to death be	ut not resu	ulting in the ur	nderlying cause give	en in Part I.		oacco use conti es 2 □ No		e cause of death?
Records,	ie law requiri has been si ge 2 should I	Completed							24a. Was ar autops perform	y p	Vere autor prior to con leath?	osy findings available apletion of cause of
a	ilcian: The certificate his rector, page	e Co	25. Was case referred to medical		 			-0.01	1 ☐ Yes 2	No 1	□Yes	2 □ No
Vital	sicia s certi	o B	examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	Hospital:	nt 2 🗆	ER/Outpatien	t 3 DOA Othe		th (Check only on ome 5 ☐ Reside		(Casaik	n - c 0000
ō	Phys er this eral dir	 	27. Manner of Death	28a. Date of Injur	у	28b. Time of	28c. Injun Worl		28d. Describe ho			102 bi d
Ö	nding F ath. r: After e funera	ig ig	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	/ Year)	Injury		<br Yes 2 □ No				
Division	al or Attendi s after death. If Director: A od in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc			eet, factory, office		28f. Location (St. City or Town	reet and Numb , State)	er or Rura	Route Number,
	To the Hospital or Att within 24 hours after d To the Funerel Direct completely filled in by i	Medical C	29a. Certifier 117 Certifying Ph (Check only one) 2 Madical Exam	ysician: To the best on niner: On the basis of and manner sta	examinat	wiedge, death tion and/or inv	occurred at the time restigation, in my of	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and ma ate and place, a	nner as st and due to	ated. the cause(s)
	To th Within Fo th	Me	29b. Signature and title of certifier				29c. Licenso	number	25	9d. Date signed		
			March	w)			1)5	8303	8	Festen	ber o	2-00-6
	3		30. Name and address of person who AANON CHRN 1823, /	completed cause of d	eath (Item	23a) (Type,	Print BA	Penar n	N 2120	4		
2.4	Sta Registi		31. Date filed (Month, Day, Year)	32. Pogistra	ar's Signal	ly de	north			r		

			For State Registrar	State of I	Maryland		artment of H		nd Mei		giene Reg. No.2001	5 28060
	Dhusiai		1. Decedent's Name (First, Middle	, Last)					2.	Date of Dea	ath Day Yea	3. Time of Death
	Physici /Medio		Elizabeth Co						5	eptem		
	Examir	ıer	4a. Facility Name (If not institution	, give street and number	er)		4b. City, Town, or	r Location of	Death	•	4c. County of D	eath
			Upper Chesapea 5. Social Security Number		Cente		Bel Air	If Under 2	4 Hrs. 8.	Date of Birt	Harfor	**
	Funeral Director		118-18-6243	1 M 2 NE	84	Yrs.	Months Days	Hours	Min.	(Month, Da	y, Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent							ine It	1922	Scotland
	how		10a. State 10b. County		10c. City,	, Town or Lo	cation					10d. Inside City Limits
	Sa-f	cto	Maryland Harfo	rd	Bel	Air						1 ☐ Yes 2√€ No
	if the	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of What	Country?
	ath v	rai	2114 Wentworth		. 5 . 11.0		210		1-0/01	V M -	USA	1-47-
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural", or items 23s or 28s-f show other, the Medical Examinar must be multish at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force ed 1 Tes 2 If Yes, Give Year or Date	es? [XX No		Vas Decedent of H f Yes, specify Cuba I □ Yes 2∑No	ispanic Orig an, Mexican, Specify:	Puerto Ric	y Yes or No- an, etc.)	Specify:	mencan Indian, hite, etc. White
21215-0036	2 hou	ted	15. Decedent			16a. Deced	lent's Usual Occup	ation	a f wardera a		16b. Kind of Busine	
215	within 7. ene. then "n	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4	or 5+)	life. l	kind of work done OO NOT use retired	during most	or working			
	filed withi Hygiene. other then	Соп	12			Homen	naker				Own Hom	<u> </u>
nd	be fited that doth	Be	17. Father's Name (First, Middle,	Last)				18. Mother	's Name (F	irst, Middle,	Maiden Sumame)	
Maryland	should be ind Mental marked o	2	Roger Kimmet			I		Marga	aret	(mmn)_	Rae	
Mar	s 1 and 2 should I Health and Mer item 27 te marke other treumatic		19a. Informant's Name/Relations		1		EATO A				er, City or Town, State	e, Zip Code)
	ges 1 and t of Healt if item 2		George Madore 20a. Method of Disposition	/ Son	20b. Pla	ace of Dispo	sition (Name of		Be. Be.		MD 21015 20c. Location - City	or Town, State
JO.	000==		1 🔀 Burial 2 ☐ Cremation		ate _ ce	metery, crer	natory or other place. Cemetery	1 1 .	9-6-06	. /		
Baltimore,	permit. Pag Department Important: I any injury c	1. /	4 ☐ Donation 5 ☐ Other (Signature of Funeral Service		ı aı.	22	Name and Addre	es of Eacility	,			, Maryland
Ba	permit. Departr Imports any inju		Steph Co	Augel		1	CComas F	uneral sbury	L Home	P.A	vadon Mara	land 21009
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	sed the death.							Approximate Interval Between
л	Physician		Immediate Cause (Final disease or condition	51	- 0/	ccal	Precin	ONG				Onset and Death
1	/Medical		resulting in death)	Due to (or	as a consequ		1000	10/119				
	Examiner		Sequentially list conditions,	b. Ep		semo	7					Sugrars
11	b si	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	ence of):						
\mathcal{W}_{n}	and and il-tran	Examiner	that initiated events resulting in death) Last	c	as a consequ	ence of):						
8760,	te be executed ysicien and e burial-transit	dical E		l.								
687	ificate g phys as the	0		U								
. Box	death certific e attending p d for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4□Pregnan	n 2 □Fetal t at time of de	death 3□	Ectopic pregnancy Other (specify)	1			23d. Date of Month	delivery Day Year
P.0	at the de by the stached	hys	9 Unknown	9□ Unknow								
	w requires that been signed should be del	þ	Part II, Other significant condition	ons contributing to deat	h but not resu	Iting in the u	nderlying cause giv	en in Part I.	_	23e. Did to	10	e to the cause of death? Probably 4 Unknown
Vital Records,	e la has	Completed								24a. Was autor perfo 1 Yes	osy prior prior death	autopsy findings available to completion of cause of ?
/ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?						of Death (C	Check only o	one)	
of \	Physic this o	ဥ	1 ☐ Yes 2 🕅 No	Hospital: 1 Drinp		ER/Outpatier		4 🗆 Nur			dence 6 Other (S	pecify)
ŭ	After t	on:	27. Manner of Death Natural 5 ☐ Pendin		Injury Day Year)	28b. Time of Injury	Wor			I. Describe I	how injury occurred	
Division	death. ctor: A y the fu	cat	2 Accident Investig	not be 200 Diago of	Injuny - At hor	me farm str	eet, factory, office	Yes 2□N		Location /	Street and Number of	Rural Route Number,
ĕ	after Direct	Certification:	4 ☐ Homicide determ	building	, etc. (Specify,)	oot, radiory, office			City or Tov	wn, State)	Transferance (Transcon,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier Certifyin	g Physician: To the be Examinar: On the basi	est of my know	vledge, deatl	n occurred at the tir	me, date and	d place, and	due to the	cause(s) and manner	as stated.
	the hin 24 the F	Medical	one)	/ and manner	r stated.							
	To To Cor		29b. Signature and title of certifie	11				1981. 1981.	9		29d. Date signed (M	
,	-		10 careo	Junea	-1.1-11.11	20-1 75	U	<i>v</i> ·			xptember	3,2006
مشن ا	P		Marco	who completed cause of 2amora	7,50	049	Per Chesa	peck	e Pri	ve E	September Sel Air,	21014
*	Sta Regist		31. Date filed (Month, Day, Year)	3 2006	istrar's Signat	16 1	neces					
	· ·	- 1	DEP U	LUUU LEE	CES A		Artical Miles					

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madore, Elizabeth m 800380962

			For State Registrar	tate of Maryland / De	partment o			ene . No. 2006	28061
	Physicia		Decedent's Name (First, Middle, Last) NORMA		MILLER		2 Date of Death	R 1, 2006	3. Time of Death 5:05 P M
	/Medic Examin		4a. Fecility Name (If not institution, give stree 10404 CASCADES RUN		4b. City, Tow	n, or Location of De OWINGS		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 M	7. Age (In yrs. last birthdom) 2 7 91 Yrs	Months Da			9. Birth	nplace (State or Foreign untry) MD
	show	or	Usual Residence of Decedent 10a. State 10b. County MD BALTIMOR	10c. City, Town o	Location	15			10d. Inside City Limits 1 ☐ Yes 2 🏋 No
	ith the M or 28a-f	Director	10e. Sireet and Number		10f. Zip Coo	de	109	. Citizen of What Co	untry?
	death w	Funeral I			3. Was Decedent	21117 of Hispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer	
920	ours after or ral', or iter Examinar	by	1 Never Married 2 Married	Armed Forces? I Tyes 2 M No f Yes, Give Year or Dates:	If Yes, specify (erto Rican, etc.)	Bfack, White Specify:	white
Maryland 21215-003	should be filed within 72 hours after death with the Maryland dd Mental Hygene marked other than "natural", or liems 23a or 28a-f show matic event, tra Medical Examinar must be notilled at	Completed	15. Decedent's Educatio (Specify only highest grade col	mpleted) (G	ocedent's Usuaf Ocive kind of work do e. DO NOT use re	one during most of v stired)	vorking	S.SCHAPIR	,
land ?	uld be filed wi Aental Hygien rked other th tic svent, Ins	To Be C	17. Father's Name (First, Middle, Last) SAMUEL	PE	CKER	18. Mother's N	lame (First, Middle, Ma	iden Sumame)	SNYDER
	and 2 should ealth and Men n 27 is marke ier traumatic	7	19a. Informant's Name/Relationship (Type, I GLORIA TANNENBAUM				Rural Route Number, C /E - BALTIM		
more,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked sny injury or other traumatic av once.		20a. Method of Disposition 1 🔏 Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	wal from State cemetery,	sposition (Name of crematory or other YOUNG ME	f place) N CEM 09/		woodlawn	
Balti	permit. Departm Importa sny inju		21. Significant of Superal Service License	Sugar	22. Name and Ad 8900 RE		SOL LEVINS NN ROAD - P		
	Physician		23a. Part1. Enter the disease, or complicatic shock, or heart failure. List only one call mmediate Cause (Final disease or condition			dying, such as card	liac or respiratory arrest	t.	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of).					
	and I-transit	Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):					
8760,	physicien and sthe burial-transit	dical	_ d						
O. Box 6	The law requires that the death certificate be executed to hes been signed by the attending physicien and bege 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?	f yes, outcome of pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 9□Unknown	3 □Ectopic pregn 5 □ Other (specify	ancy /)		23d. Date of deli Month	very Day Year
α.	uires that I signed by id be detai	ρ	Part II. Dther significant conditions contribu	uting to death but not resulting in th	e underlying cause	e given in Part I.	23e. Did toba	cco use contribute lo	
Vital Records,		Completed					24a. Was an autopsy performe	d? death?	topsy findings available completion of cause of
VIII	ysician s certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hosp	ital: 1 ☐ Inpatient 2 ☐ ER/Outpa	itient 3 DOA	Othor	Death (Check only one) The Home Sections	ce 6 ☐ Other (Spec	er(v)
Division of	Jing Afte			8a. Date of Injury (Month, Day Year) 28b. Tim Injur		Injury at Work?	28d. Describe how		
Divis	al or Attands after death	Certification:	3 Suicide 6 Could not be determined 2	8e. Place of Injury - At home, farm, building, etc. (Specify)	, street, factory, of	fice	28f. Location (Stree City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edicai (29a. Certifier (Check only one) 1 Certifying Physicia 2 Medical Examiner:	in: To the best of my knowledge, d On the basis of examination and/o and manner stated.	eath occurred at the rinvestigation, in r	ne time, date and pla my opinion, death oc	ace, and due to the causecurred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
)	To the within 2 To the complet	W	29b. Signature and little of certifier	JIWV	29c. Li	cense number	9 (290	Date signed (Month)	Day, Year)
	8		30. Name and address of person who compl	eted cause of death (Item 23a) (Ty	pe, Print) 000	old la	not Nd;	Jalt: Lor	170429
ė	Sta Registr		31. Date filed (MoSTETE) 1998 2006	32 Registrar's Signature	parte				

State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 31, 2006 **Physician** MOGUL 5:05 P FRANCES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE MILFORD MANOR NURSING HOME BALTIMORE 7. Age (In yrs. last birthday) tf Under 1 Year If Under 24 Hrs.

OO Yrs. Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛭 F 89 1170871916 214-14-4929 MD Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow rthan "natural", or itema 23a or 28a-f aho the Medical Examinar must be notified at 1 X Yes 2 No Director MD N/A BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? deeth with USA 3601 FORDS LANE #819 21215 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify: Be Completed by Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **ACCOUNTANT** SWEETHEART CUP s 1 and 2 should be filed v if Health and Mental Hygie Item 27 is marked other t other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **BOGAT** SOL RAE MARMOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Paral Route Number, City or Town, State, Zip Code) Pages 1 and 2 s rtment of Health ar intent: if item 27 is injury or other tra 11507 ASBURY COURT - WHITE MARSH, MD 21162 JOAN GARRITY / DAUGHTER Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment important: if any injury or 09/03/2006 BALTIMORE HEBREW CEM | REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) DNGESTIVE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). and A burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Be Completed by Physician/Medical as the ettending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐ Pregnant at time of death 5 Other (specify) of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC ORSTRUCTIVE PULMUNARY 23e. Did tobacco use contribute to the cause of death? DISEASE 1 Yes 2 No 3 Probably 4 Miknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy 20 No 1 Yes or Attending Physician: after death.

Director: After this certific 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 € No 4 Aursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how intury occurred Division 5 Pending investigation 16 Natural 1 Tes 2 No 2 Accident 6 □ Could not be 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide pelli within 24 hours a
To the Funerei C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

7220 PARK HEIGHTS AVE)

Name and address of person who completed cause of death (Item 23a) (Type, Print),

HANI

32 Registrar's Signature

ASNERM

31. Date filed (Month, Day, Year)

SFP 0 6 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien

			1 - State Registrar	State of Ma	•	Department of F Certificate of			giene	00	20000
		ų į	1. Decedent's Name (First, Middle, Las	st)			•	2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic		Yolanda Lugo	n McKay					nber 2,	2006	1:15 A ^M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County	of Death	
	-	# .	Rockville Nursing 5. Social Security Number 6. S		da um iant hist	Rockvi	lle If Under 24 Hrs.	8. Date of Birt	Mont	gomer	
- 13 - 25	Funeral Director			M 2€F 7. Age	(In yrs. last birt	Yrs. Months Days	Hours Min.	July 24	y, Year)	Cou	place (State or Foreign intry) ivia
100	*		Usual Residence of Decedent		04			July 2	+, 1922	D01	IVIa
	inylan show	L	10a. State 10b. County		10c. City, Town						10d. Inside City Limits
	Ba-f e	Director	Maryland Montgo	nery	Rockvi						Yes 2 No
	with th	Dir	10e. Street and Number			10f. Zip Code	0		10g. Citizen of		intry?
	eath	Funerai	303 Adclare Road	12. Was Decedent E	ver in U.S.	20850		ecrfy Yes or No	Boliv		can Indian,
(0	riter of	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2√7 N If Yes, GiveX		13. Was Decedent of H				ick, White,	, etc.
ğ	rei', o	l by	3 Widowed 4 ☐ Divorced	If Yes, Give∧ Year or Dates:		1 XYes 2□ No	Specify: Bol	livian	Specil	y: Wh	nite
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland ind Mental Hygiene. I have smarked other then "naturel", or items 23a or 28a-f ehow umatic event, the Moulcal Exeminational be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of work	ing	16b. Kind of B	lusiness/lr	ndustry
12	within ane. then	mpl	Elementary/Secondary (0-12)	Coflege (1-4or 5-	+)	Statisticia			O.A.	S.	
9	filed Hygir other ent, 11	CC	17. Father's Name (First, Middle, Last)	<u> </u>		o cat 15 c 1 o 1	18. Mother's Name	e (First, Middle,			
an	lid be ked c	To Be	Pablo Lugon Y	Vallaton			Eloina	a Lugon			
ary	shou and N s mai		19a. Informant's Name/Refationship (19b.	Mailing Address (Street			er, City or Town	, State, Zi	p Code)
Σ	and 2 ealth n 27 i		Martha B. Kreve	re/dau_hte		0515 Wicken	s Road, Vi	ienna, V	VA 221	81	
Baltimore,	or oth		20a. Method of Disposition 1 Burial 2 Tremation 3	Removal from State	cemeter	Disposition (Name of y, crematory or other pla		tember	20c. Location		
<u> </u>	tment tant:		4 □ Donation 5 □ Other (Specific	y)	Montgo	omery Crema		2006	Bethes	da, M	Maryland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene inportant: if I term 21 is marked other then "naturel", or items 23a or 28a-1 ehow any injury or other traumatic event, the Modical Examinational be notified at once.		21. Signature of Funeral Service Licer William U. Fun	womey	MO1173	Pobert A. Fu	mphrey Fune in Avenue. I	ral Home, Bethesda:	Bethesda Mary Land	-chex	Chase, Inc.
2.			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do n	not enter the mode of dyi	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition	a Septio	cemia						Onset and Death
	/Medical Examiner		resulting in death)	\$4000 E 2	consequence of						
	7.2	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		consequence	Heart Dise	ease			-	
Jd.	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or infury that initiated events	Diabet	tes Mell	itus					
o,	en an rial-tr	Еха	resulting in death) Last		consequence of						
68760,	lificate be executed g physicien and as the burial-transit	edical	(d. <u>Dement</u>	tia						
	entific ling pl		IF FEMALE:								
Вох	eath cerr attendin for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1	2 🗌 Fetal death	3 Ectopic pregnanc	у			ate of deliv onth	ery Day Year
o i	the de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	ume or death	5 Other (specify)					
Division of Vital Records, P.O.	res that the de signed by the a l be detached f	by Ph	Part II. Other significant conditions of	ontributing to death bu	it not resulting in	the underlying cause given	ven in Part I.	23e. Did to	obacco use con	tribute to I	the cause of death?
rds	w requires been sig should be	ed b						101	res 2□No	3 Pro	bably 4 Dunknown
၀	aw re	Completed						24a. Was		Were auto	opsy findings available
Ä	The lay	mo						autop perfo 1 Yes	rmed?	death?	ompletion of cause of 2 No
/ita	clan: ertifici octor,	Be	25. Was case referred to medical examiner?				26. Place of Deatl				
<u></u>	Shysia this call dire	은	1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatier		tpatient 3 DOA	ner: 4 📉 Nursing Ho				fy)
UC	ding f	:lou:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		n _f ury Wo	ryat rk? Yes 2 □No	28d. Describe i	now infury occur	rred	
18:	Atten deatl ctor: y the	fical	2 Accident investigation 3 Suicide 6 Coufd not b	9 290 Place of Injur	ıry - At home, fai	rm, street, factory, office		28f. Location (S	Street and Num.	ber or Rur	al Route Number,
	el or / s efter i Dire	Certification:	4 Homicide	building, etc	. (Specify)	, , , ,		City or Tov	vn, State)		
	To the Hospitel or Attending Physician: The law requires that the death cert within 24 hours elter death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use and the completely filled in by the funeral director, page 2.		29a. Certifier Certifying Ph	ysician: To the best of	of my knowledge	, death occurred at the ti	me, date and place,	and due to the	cause(s) and m	anner as s	stated.
,	the hin 24 the F	Medical	one)	and manner sta					1.3		``
	50 7 Kit		29b. Signature and title of certifier	V. So	MALA	29c. Licens	47330		29d. Date signe Septem		
	h		Momis and address of parson who		1		.,,550		peptell	DET 1	, 2000
	り		30. Name and address of person who Thomas V. Joseph, N			1.	ckville. Man	rvland 2	0852		
	Sta		31. Date filed (Month, Day, Year)	32. Peristra	r's Signature	10,10		- y			
	Registr	ar	SEP 0 6 2	2006	in S.	Sparke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2005

			1 - State of Registrar		artment of Health and rtificate of Death	d Mental Hygie		3064
1	Physici /Medic		1. Decedent's Name (First, Middle, Last) Joy Sutherland Neidl	inger.		2. Date of Death Month AUG 31,	Day Year 3. Tim 5:1	ne of Death
	Examin Funeral			Columbia . Age (In yrs. last birthday	4b. City, Town, or Location of De Columbia If Under 1 Year If Under 24 H Months Days Hours N		4c. County of Death Howard 9. Birthplace (Sta Country)	ate or Foreign
- Sels-	Director		560 - 24 - 0781	83 Yrs.		MAY 28,	1923 Califor	rnia le City Limits
	r 28a-f sho	Director	MD Anne Arundel 10e. Street and Number	Annapoli	. S 10f. Zip Code	10g	1 🗆 1	Yes Z. No
36	be filed within 72 hours after death with the Maryland ital Hyglene do ther than "neture!", or iteme 23a or 28a-f show other than "neture!", or iteme 23a or 28a-f show event, the Madical Examical must be notified at	by Funeral D	840 Singing Hills Ct 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	dent Ever in U.S. 13. ces? 2 No	21401 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Polyton Specify:	(Specify Yes or No- uerto Rican, etc.)	USA 14. Race - American Indian Black, White, etc. Specify: White	n,
Maryland 21215-0036	d within 72 hour giene. ir than "neturel	Completed b	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4	16a. Dece (Give life.	Ident's Usual Occupation kind of work done during most of DO NOT use retired) Chemist	working	b. Kind of Business/Industry Food Research	h
aryland ;		To Be C	17. Father's Name (First, Middle, Last) Robert La Verne Suth 19a. Informant's Name/Relationship (Type, Print) Hu		Alice	Name (First, Middle, Ma Ladew r Rural Route Number, C		20904
Baltimore, M	es 1 and of Health if item 27 or other tr		Robert. W. Neidlinger 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from S 4 Donation 3 Other (Specify)	20b. Place of Disp cemetery, cre	2 Gracefield ostion (Name of matory or other place) rematory, Inc9	Date 20	05 Silver Spr c. Location - City or Town, State altimore, MD	
Balti	permit. Pag Department Important: I eny injury o		C- 7112	dd Dring Ĉ	2. Name and Address of Facility. remation Soci 99 Frederick	ety of Ma Rd Baltim	ryland, Inc.	8
8760,	Physician /Medical Examiner	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	used the death. Do not erch line. ent c 0 lost or as a consequence of): or as a consequence of):		anary de	Onset	Between and Death Years
O. Box 687	ath certificate attending phys for use as the	Physician/Medical	in the past 12 months?	ant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day	Year
rds, P.	quires that the de on signed by the a uld be detached to	ρ	Part II. Other significant conditions contributing to dear Type I Diabetes	ath but not resulting in the Mellitu	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause	of death?
Il Records,		Completed	'			24a. Was an autopsy performe	24b. Were autopsy finding prior to completion death?	
Division of Vital	or Attending Physician: The ta after death. Director: After this certificate ha in by the funeral director, page?	Certification: To Be	27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined	patient 2 ER/Outpatie f Injury n, Day Year) 28b. Time Injury of Injury - At home, farm, s g, etc. (Specify)	ont 3 DOA Other: 4 Nursing of 28c. Injury at Work? M 1 Yes 2 No	Death Check only one g Home 5 Residence 28d. Describe how 28f. Location (Streen City or Town.)	injury occurred et and Number or Rural Route	wing Number.
_	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Physician: To the control one) 2 Medical Examiner: On the base and mann	best of my knowledge, dea sis of examination and/or i er stated.	th occurred at the time, date and provestigation, in my opinion, death of	lace, and due to the caus	se(s) and manner as stated. a and place, and due to the cau	ise(s)
)	To t To t	×	29b. Signature and title of certifier	, m.D.	29c. License number	531	Date signed (Month, Day, Yea	ar) 306
	Sta	ate.	30. Name and address of person who completed cause Harry Li, 19780 31. Date filed (Month, Day, Year) 32. Be	e of death (Item 23a) (Type Hickory R egistrar's Signature	29c. License number D 56 s. Print) Printly Adge Rd, Columnia	mbia, 1	nd 21044	
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			1 - For Amend #5	State of Marylar Per FH G859	9/14/06	artment of F	Health and M Death	ental Hygi	ene2006	28065
			Decedent's Name (First, Middle, La.					2. Date of Death		3. Time of Death
	Physici		Richard Edward	d Nonn				09/01/	2006	1:35 A ^M
	/Medic Examin		4a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of Death	00,01,	4c. County of Deel	
	Lxamiii	٠.	199 Greenland	Beach Road		Balti	more		Anne Ar	_
	Funeral		5. Social Security Alumber 6. S	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		hplace (State or Foreign
	Director		212-26-8688	1 X M 2□F 72	Yrs.	Months Days	Hours Min.	11/10/	1933 Co	MD
	D		Usual Residence of Decedent							
	nylan how		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Ma Hillied	ioi	MD Anne A	rundel F	Baltim	ore				1 ☐ Yes 2 No
	death with the Maryland ms 23e or 28e-f show trrust te natified at	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	th wil		199 Greenland	Beach Road		2122	:6		U.S.A.	
	dea	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto I	city Yes or No-	14. Race - Ame	
٥	atter or Ite		1 Never Married 2 Married	1 Yes 2 No		1 □ Yes 2 1 No		rican, etc.)	Black, Whit	e, etc.
3	hours atter turel', or Ite	l by	3 Widowed 4 Divorced	Year or Dates:		TO THE ZINO	Sp e city:		Specify: W	hite
9500-612		Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a. Deced	dent's Usual Occup	ation during most of working	10	6b. Kind of Business/	Industry
7	within 72 ene. then "nat	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired	d)	<i>'</i> 9		
7	filed wi Hygien ther th	9	6		Shee	t Metal	Worker	В	eth1ehem	Steel
land	0 E 5 8	Be (17. Father's Name (First, Middle, Last,)			18. Mother's Name	(First, Middle, M.	aiden Sumame)	
<u>a</u>	should but and Ment marked	0	Richard Nonn				Doris	Kerr		
Mar	is 1 and 2 should by Health and Ment item 27 is marked: other treumatic e		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street	and Number or Rura	l Route Number,	City or Town, State, 2	Zip Code) 21226
	and 2 salth n 27 i		Joan Nonn / W	ife	199	Greenla	nd Beach	Road,	Baltimo	re, MD
ē,	is 1 a of Hear item other		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other place	ce) D	ate 2	Oc. Location - City or	Town, State
Ē	Pages nent of nnt: If it nry or o		1 Burial 2 □ Cremation 3 □ 3 4 □ Donation 5 □ Other (Specif	_Hemoval from State	-			5/06	Glen Bur	nie. MD
altimor		1	21. Signature of Coneral Service Licer							Home, PA
ñ	permit. Departr Importe eny inj	. 4	1/2/1		-				adena, M	
	vá.		23a. Part1. Enter the disease, or com	plications that caused the dear						Approximate
		1	shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	_				.,	Interval Between Onset and Death
	Physician (Madical		disease or condition resulting in death)	_ d		ENAC	DISEASO			YEARS
	/Medical Examiner		Todaking in doday	Due to (or as a consec)				VEALC
		_	Sequentially list conditions,	b. HYPERT		010				TOMES
	De sis	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence or):					
0	and trans	Examin	that initiated events resulting in death) Last	C						
Š,	be executed ician and burial-transii		Tooling in coalin, cast	Due to (or as a consec	quence oi):					
8/60,	licate be executed physician and s the burial-transit	dicai		_ d						
0	ing p	Mec	IF FEMALE:							
X Q Q	death certitic e attending p id for use as	ian/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy	/		23d. Date of deli	ive ry Day Year
	ed to	sici	1 ☐ Yes 2 ☐ No	4□Pregnant at time of o	death 5□	Other (specify)			Month	Day Tear
r Ö	that the de ned by the a detached t	Physici	9 🗆 Unknown				170			
ູ້ ທໍ	8 50	β	Part II. Other significant conditions of	ontributing to death but not res	sulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba	icco use contribute to	
ā	w require been si should t							1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Onknown
Hecords,		Completed						24a. Was an	24b. Were au	topsy findings available
ř	The I	E						autopsy performe	ed? death?	completion of cause of
VIIal		0	25. Was case referred to medical				26. Place of Death			2 NO
	Physicien: this certitic at director,	O B	examiner?	Hospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Oth	25		ce 6 □Other (Spec	rifu)
ō	ding Phys h. After this tuneral di	1:1	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injur	y at 2	8d. Describe how		,iiy)
5	ding th. Afte	tio	1 Avatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 1 🗆	k? Yes 2 □ No			
S	deal deal ctor.	fica	3 Suicide 6 Could not b	O Diago of laines At h	ome, farm, str	eet, factory, office	2	8f. Location (Stre	et and Number or Ru	ral Route Number
DIVISION	atter Dire	Certification:	4 Homicide determined	building, etc. (Special	fy)	000, 1201019, 011100		City or Town,		74.71001011007,
_	pitel ours erel filled	Ö	29a. Certifier 1 Certifying Ph	nysicien: To the best of my kno	awledge death	accurred at the tir	no date and place a	nd due to the cou	una(a) and manner an	atatad
	Hos 24 hc Fun stely	edical	(Check only 2 Medical Exer	miner: On the basis of examina	ation and/or inv	estigation, in my o	pinion, death occurre	d at the time, dat	e and place, and due	to the cause(s)
	To the Hospitel or Attending within 24 hours atter death. To the Funerel Director: After completely filled in by the tuner	Mec	29b. Signature and title of certifier	and mainter stated.		29c. Licens	e number	294	d. Date signed (Mont)	n Dav Year)
	¥ × S		la !	hTitas-		1	0 7 0 7	250	7 / / "	., _ wy, . war/
			· carro,	140110		52	7007		7/1/06	
	2		30. Name and address of person who	completed cause of death (Iter	п 23а) (Туре,	Print)		G	LEN BU	RNIE
	V		CARLOS D. ZIG	EC, M. 12, 5	UITEIO	6 1406	SICIZAIN F	twy. 1	MIALYCIAN	n, Day, Year) PLY (Full Street of S
H	Sta		31. Date filed (Month, Day, Year)	32. Hegistrar's Signa	ature	50 P 8				
	Registr	ar	GED 0 6 20	106 Bales	15 Las	STATE OF				

State of Maryland / Department of Health and Mental Hygiene 2005 28066 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Richard Marbury Nelson 0050 AM September 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) November 29, 1933 Mary Land 9. Birthplace (State or Foreign **Funeral XX**M 2□ F Director 215-30-7821 72 Vrs Usual Residence of Decedent fited within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be mailfied at 1 Yes 2 □No **Funeral Director** Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 West 40th Street 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22010 If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: White Completed by 3 Widowed WDivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Accountant U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fit iment of Health and Mental H tant: If Item 27 is marked other. Cleland Kinloch Nelson Marion Contee Moale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Stoughton Nelson DTR 202 North Marquette Street Madison Wisconsin 53704 other i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State permit. Pages
De artment of H
Important: If Ite
any injury or of 9/8/06 Donation 5 Other (Specify) St Thomas Episcopal Owings Mills, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 21 Signature of Funeral Service Licensee muss 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the dise e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis **Physician** disease or condition resulting in death) two days /Medical Due to (or as a consequence of): Examiner Prolymphocytic leukemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 - Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown s been signed by the should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 XNo or Attanding Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No 1 Inpatient Other: Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28b Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Accident the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 1x Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical completely Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00052391 2006 eus K 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memoria Hospital Levis 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 6 2006

			1 - State of Maryland / De State of Maryland / De	epartment of Health and M Ce <i>rtificate of Death</i>	Mental Hygiene 2006 28067
	Dhysis	20	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year 3. Time of Death
	Physici /Medi		Mary Osborne		Sep. 4, 2006 9:30 MA
	Examir	ier	4a. Facility Name (If not institution, give street and number) 2439 Ashton Street	4b. City, Town, or Location of Death	4c. County of Death
_	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth)	Baltimore day) If Under 1 Year If Under 24 Hrs.	N/A 8. Date of Birth 9. Birthplace (State or Foreign
Н	Funeral Director		216-36-6348 1 M 2 NF 66 Yr	Months Days Hours Min.	Oct. 10, 1939 MD
	D >		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	-1	
	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-1 show important: if item 27 is marked other then "natural", or iteme 23a or 28a-1 show all pay injury or other traumatic event, the Medical Examinar must be notified at Anne.	ច			10d. Inside City Limits 1X Yes 2 ☐ No
	28a-f	Director	MD N/A Baltimo 10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	3a or		2439 Ashton street	21223	
	deeth me 2:	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No. 14. Race - American Indian,
ထ္	after or ite	Ē	Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes. 2 ☑ No If Yes. Give	If Yes, specify Cuban, Mexican, Puerto 1 Tyes 2 No Specify:	
ဗ္ဗ	nours iral',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	whi	***************************************
7	"nati	Completed	(Specify only highest grade completed) (6	ecedent's Usual Occupation Give kind of work done during most of work ife. DO NOT use retired)	ing 16b. Kind of Business/Industry
12	withir ene. then	Ę	Elementary/Secondary (0-12) College (1-4or 5+)	pervisor	Conitation Description
დ დ	ould be filed v Mental Hygie karked other t	Be Co	17. Father's Name (First, Middle, Last)		Sanitation Department o (First, Middle, Maiden Sumame)
au	Ald be Mental rked ricev	To B	Thomas Burch	Marie F	Price
ary	2 should and Men is marke		19a. Informant's Name/Relationship (Type, Print) 19b. 8		al Route Number, City or Town, State, Zip Code)
Σ	end a Baith n 27 i		Jessie Osborne Sr Husband 24	39 Ashton Street Ba	Itimore, MD 21223
ore	of He		20a. Method of Disposition 1 ☐ Buriai 2 점 Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery.	risposition (Name of crematory or other place)	Date 20c. Location - City or Town, State
Ē	Pages tment of tant: if it jury or o		4 □ Donation 5 □ Other (Specify) Metro	Crematory Sep.	6, 06 Ealtimore, MD
Baltimore, Maryland 21215-0036	permit. Departr imports eny inj		21. Signature of Funeral Service Lifensee	Cremation Society	of Maryland, Inc. Baltimore, MD 21228
	40200	\vdash	222 Bit 1 Enter the disease or complications that offerd the death. To see	299 Frederick Road	Baltimore, MD 21228 or respiratory arrest. Approximate
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complications that pussed the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate	all Lung (a	Interval Between Onset and Death Onset and Death
58760,	The law requires that the death certificate be executed site has been signed by the attending physicien and coge 2 should be detached for use as the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C	:	
.O. Box 6	that the death certificed by the attending of detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2≥5 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ⊟Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
rds, P	tw requires that s been signed E s should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	he underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, P.O.	: The law receive has be pege 2 she	Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
<u> </u>	Physician: Th r this certificete ral director, peg	Be	25. Was case referred to medical examiner? Hospital:	Othor	h (Check only one)
ŏ	Phys r this oral di	٦. ا	1	allett 30 DOA 4 Hursing Ho	me 5
O	Attending r death. ector: After by the fune	tlor	1 In Matural 5 Pending (Month, Day Year) Inju		,
VIS	Attendi r death. ector: A by the fu	IIIC	3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm	street, factory, office	28f. Location (Street and Number or Rural Route Number,
Ö	s after ni Dire	Certification;	4 Homicide Soldmines building, etc. (Specify)		City or Town, State)
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/a and manner stated.	or investigation, in my opinion, death occurr	red at the time, date and place, and due to the cause(s)
1	To the within 2	2	29b. Signature and title of certifier South A User Elvo, Mo	29c. License number 29c. 24532	29d. Date signed (Month, Day, Year) SEPTEMBER 05, 2016 VEET, 13c / HIMENE, M & 21225
	9		30. Name and address of person who completed cause of death (Item 23a) (Tr. DAVID A. UKN B. HU, MD 300	ype. Print) 01 S-KANOVER St	red, 130/timore, Md21225-
	Sta Registi		31. Date filed (Month, Day, Year) SEP 0 6 2006	AGE)	-

			1 - For Amend #1 Per	State of Marylan Phy G859 9/0	d / Departme 6/0 ©eHfica	nt of Health and te of Death		ene 2006	28068
	Physici	an	1. Decedent's Name (First, Middle, Last)	il	. O'Donnel		2. Date of Death	Day O Year	3. Time of Death
}	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give s CONCSIS Randalls 5. Social Security Number 481-14-0066		buty Road	y, Town, or Location of Dea	stown 8. Date of Birth	4c. County of Death Ba Hind 9. Birthple Count 10W	
	D	J.	Usual Residence of Decedent 10a. State	10c. Cit	y, Town or Location ndallsto	wn	3/21/1		d. Inside City Limits 1 Yes 2 No
	with the M e or 28a-f Lbe notifie	Funeral Director	10e. Street and Number 9109 Liberty Roa	ad		ip Code 1133	10g	. Citizen of What Count	
36	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or items 23e or 28e-f show ther, the Mackeal Examinatr mat be notified at	by Funeral		2. Was Decedent Ever in U. Armed Forces? 1	S. 13. Was Dec	edent of Hispanic Origin? (ecrify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - America Black, White, e	
, Maryland 21215-0036	ithin 72 hour ne. nen "neturei Medical Ex	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Sales				orking	16b. Kind of Business/Industry	
	id be filed w ental Hygier ked other th ic event, in	To Be Cor	17. Father's Name (First, Middle, Last) Alphonsus O'Doi	2 nnell	Autom	18. Mother's Na	ime (First, Middle, Ma th Cole	Automotiv	7e
	and 2 shoul		19a. Informant's Name/Relationship (Typ. James O'Donnell,	/Son	7995 C	opperfield	Circle J	[acksonvi]	lle,Flori
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or Itema 23e or 28e-f show any injury or other traumatic event, the Medical Examinator and be notified at anone.		20a. Method of Disposition 1	ernovalirom State	PHIL	m.Park 9/01 TP ^{Ad} OSSRTWALI	1/06 S. DI FUNERA	Charlesto SERVICE	on,WV.
	Physician /Medical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Shock, or heart failure. List only one cause on each line. Interval Betwoen Condition on the cause (Final disease or condition resulting in death) Due to (or as a consequence of):						Approximate Interval Between Onset and Death	
,8760,	ficate be executed physician and is the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): d.						
	The law requires that the death certific 11e has been signed by the attending p 2ge 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	pregnancy specify)		23d. Date of deliver Month	y Day Year		
rds, P	w requires that been signed b should be deta	۵	Part II. Other significant conditions con	tributing to death but not res	ulting in the underlying	cause given in Part I.		cco use contribute to the	e cause of death?
al Records,	The law requate has been page 2 should	Completed					24a. Was an autopsy performe	prior to com	sy findings available ipletion of cause of
<u> </u>	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:	26. Place of Death (Check on Other.				
Division of Vital	ding Phys T. After this funeral di	tlon: To	27. Manner of Death t Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M M 28c. Injury at Work? M 28c. Injury at Work? M 1 Year) M 28c. Injury at Work? M M 1 Yes 2 No					
Divisi	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, facto		28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical C	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death occurre tion and/or investigation	d at the time, date and place on, in my opinion, death occ	e, and due to the caus urred at the time, date	se(s) and manner as sta and place, and due to	ited. the cause(s)
	To the H within 24 To the F complete	Me	29b. Signature and title of certifier	000	2	9c. License number	. 1	. Date signed (Month, D	
•	h		30. Name and address of person who co	mpleted cause of death (item	n 23a) (Type, Print)	10005641	4 4	ugust 30, Ulstawn,	200G
	Sta	te.	Jocelyn N. E 31. Date filed (Month, Day, Year)	1 - Sayed 32. Registrar's Signa	9109 Li	berty Koa	d, Kando	ulstown,	MJ 21133
	Registr		SED 0 6 2006	Flower & He	Boards?				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 28069 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Scott Clifford Owen, Jr. SEP 2006 5:45a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Continuum Care Sykesville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 M 2 F Months Days Hours Min. Yrs. Director 176-24-5831 74 Pennsylvania Usual Residence of Decedent illed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Directo Maryland Eldersburg Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 USA 1640 Pine Knob Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 □ No Korean IYes, Give Conflict Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within in and Mental Hygiene.
7 Is marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) Energy Systems Program Coordinator 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mabel Irene Olson Scott Clifford Owen 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is n any injury or other traum 900.9. Harold Owen (son) 1640 Pine Knob Road Eldersburg, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation SEP 6, 2006 Sykesville, MD 22. Name and Address of Facility
Haight Funeral Home & Chapel
P.U. Box 195 Sykesville, FID 21784 (410-795-1400) 21. Signature Funeral Service Licensee Louar X 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) WOME /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit atlending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 No 9 Unknown 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Tes 2 → 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed this certificate Yes 1 ☐ Yes 2 ☐ No Physiclan: : After this certification of funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Voluming Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Attending 1 Z Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ŏ within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0005813

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Wilbur

Stone

Westmuster MO 2115

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

6 2006

			1 - For State Registrar	State of Maryland		artment of Heal		ental Hygie		6 28070
ı	Physici	an	Decedent's Name (First, Middle, Last)	7	\			2. Date of Death	Day Year	3. Time of Death
j	/Medio	al	4a. Facility Name (If not institution, give s		Jr.	4b. City, Town, or Loca	ation of Death	September	4c. County of De	
		<u>.</u>	Gilcrest center			Tows				1014
	Funeral Director		F10 00 00 10	7. Age (In yrs. last	Yrs.		ours Min.	8. Date of Birth (Month, Day, Ye 13.31./	9. B 9.35	irthplace (State or Foreign Country)
	yland		Usuel Residence of Decedent 10a. State 10b. County	10c. City, 1	own or L	ocation				10d. Inside City Limits
	8a-1 st	Director	MD Baltimo	re 7	hano	lalistown			·	1 □Yes 2 No
	s with th		10e. Street and Number 9914 Shash	me CI		10f. Zip Code	32	10g.	Citizen of What (Country?
	ems 2	Funeral	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of Hispani If Yes, specify Cuban, Me	ic Origin? (Spec exican, Puerto F	cify Yes or No-	14. Race - An Black, Wh	nerican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-1 show any Injury or other traumatic event, the Modical Exemplant must be notified at ance.	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 AYes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No Sp	ecify:		Specify: B	
21215-0036	72 hou	eted	15. Decedent's Educ (Specify only highest grade	ation 1 completed)	(Give	dent's Usual Occupation kind of work done during	most of workin	g 16t	o. Kind of Busines	s/Industry
121	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	inst	a	alterano	Citil
nd 2	be filed htal Hygi od other event, I	Be Co	17. Father's Name (First, Middle, Last)	19ears	pu	18.1	Mother's Name	(First, Middle, Mai	den Sumame)	ciry
Maryland	should bind Ment	Tof	Calvin W Parker Sc		40h 44-10		ary E	Hall		
	and 2 st eelth and n 27 ie n	1	19a. Informant's Name/Relationship (Typ. Pheo invald Parker B	other G	147	ng Address (Street and N 3 W. lafayel	A. I	Baltima		
ore,	of Hee		20a. Method of Disposition 1 ⚠ Burial 2 ☐ Cremation 3 ☐ R	20b. Plac		osition (Name of @ matory or other place)	Da	ate 200	. Location - City of	or Town, State
Baltimore,	it. Pages intment of l intent: If its injury or o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Gari	risan	Acrest 2. Name and Address of F	9.8.0	060 0	Wingsn	ndb, mo
Ba	permit. Departrimports any Inji		Vaulu C. Cin		8	728 Liberty	Ted Ran	dallstrum	MD 8	21133
			23a. Part1. Enter the disease, or complications, or heart failure. List only on	eations that caused the death. e cause on each line.						Approximate Interval Between
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Bladder	Ca	ncer				Onset and Death
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V	be sit	iner	Sequentially list conditions, if any, leading to intribulate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	iea of):					
(ate be executed hysicien and the burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequen	nce of):					_
8760,	icate be executed physicien and s the burial-transit	dicai								
ယ္	certif nding se as	/Mec	IF FEMALE: 23b. Was decedent pregnant 23	Bc. If yes, outcome of pregnancy					23d. Date of d	elivery
Box	thet the death led by the atter detached for u	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)			Month	Day Year
P.0.	The law requires thet the to the tax been signed by the bage 2 should be detache	, Phy	9 ☐ Unknown Part II. Other significant conditions con		ng in the u	inderlying cause given in I	Part I.	23e. Did tobac	co use contribute	to the cause of death?
rds,	w requires the been signed I should be det							1)XYes	2 □No 3 □ I	Probably 4 Unknown
eco	law requ	Completed						24a. Was an autopsy	prior to	autopsy findings available completion of cause of
Division of Vital Record	n: The ficate I		25. Was case referred to medical					performed 1 ☐ Yes 2		s 2 No
₹	Physician: r this certific ral director,	To Be	examiner?	ospital:	/Outpatie	1 04		(Check only one)	e 6 ⊠Other (Sp	ecity) hospio
o uc	ling Pt. After th uneral		27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28	b. Time o	f 28c. Injury at Work?	2	8d. Describe how i		
Visio	Attending ir death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home	e, farm, st	M 1 ☐ Yes				Rural Route Number,
	itel or irs afte rai Dire		4 Homicide	building, etc. (Specify)				City or Town, S	ŕ	9
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one) Quantifier (Check only one) Quantifier Qu	ician: To the best of my knowle er: On the basis of examination and manner stated.	dge, dear and/or in	h occurred at the time, da vestigation, in my opinion	ite and place, a n, death occurre	nd due to the caus d at the time, date	e(s) and manner a and place, and di	as stated. ue to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	0		29c License num	nber	29d.	Date signed (Mor	nth, Day, Year)
}	N		· yerar	un is		D 58	502	Se	premise	5 2006
	\V		30. Name and address of person who co	// / / /	Ba) (Type,	Charles ST	r BATT	more my	21204	
Ÿ.	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	e Ad	braste				
b	Registr	ar	SEP 0 6 2	UUT PROJECT A	6.1					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Elizabel 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Care Ctv. Baltumore Baltimore If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 F Director 216-10-1961 87 June 22 1919 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28e-f ehow The Mudical Examiner must be notified at 1 TYes 2 □ No Director NA Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5505 Bayview Circle 21224 U.S.A. Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Lane Bryant Clothier NA Sales Associate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental le marked Williams Harriet Schultz 2 Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Apt. C-6 3531 E. Northern Parkway Balto., Md. 21206 Caro1 Pfeffer (Daughter) 20b. Place of Disposition (Name of cometery, crematory or other place | September 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If Ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland Meadowridge Memorial 6,2006 22. Name and Address of Facility
W. Dabrowski/Chojnacki Funeral Homes P.A. 21. Signature of Furteral Service 1005 Dundalk Ave. Baltimore, Maryland 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final stage dementia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Dressure. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician end the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? t ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ INTORP ~om 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Sat certificate ral 2□ No 1 Yes 2 1 No 1 Yes the Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 2 1 ☐ Yes 2 ☐ No 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funerel D 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical npletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7768 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOPKINS 5505 Bayuan Circle tunoc 32. Registrar's Signature 31. Date filed (Month, Day Year) 6 2006 Registrar

			1- State of Maryland / Department of Health and Certificate of Death	Mental Hygi	ene 200	6 28072			
	Physici	an	Decedent's Name (First, Middle, Last) Eobby Edward Phillips	2. Date of Death	Day Year	3. Time of Death			
>	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea HARbin ALT; MURP		4c. County of Dea	th			
	Funeral Director		5. Social Security Number 217-40-4519 6. Sex 1 Months Days Hours Min		Year) L943 NY	thplace (State or Foreign ountry)			
	aryland show	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Baltimore City Baltimore			10d. Inside City Limits 1 → Tes 2 □ No			
	be filed within 72 hours after death with the Maryland tial Hygiene. ed other than "naturel", or items 23e or 28e-f ehow event, the Medical Examiner must be notified at		10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	ountry?			
9			3009 Mallview Road 11. Marital Status 1 □ Never Married Z Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, specify Cuban, Mexican, Pue 1 □ Yes 2 □ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Whi	te, etc.			
Maryland 21215-0036			3 Widowed 4 Divorced Feat or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	orking 1	Specify: B1 6b. Kind of Business				
d 212			Elementary/Secondary (0-12) College (1-4or 5+) Construction Mechanica	al Insp. Ba		y Government			
ırylan	should be ind Mental marked c		Franklin Phillips Carolin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fi	ne Brown					
e, Ma	d 2 s th ar 7 ie trau		Mr. Walter Phillips/Son 302 Bishop Avenue Br 20a. Method of Disposition 20b. Place of Disposition (Name of	ooklyn, M					
Baitimore,	Page nent o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Inc	sep 6	Beltsville,				
Ba	permit. Departimporte any inji		21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286- 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate						
	Physician physician physician and physician and physician and physician and physician and physician physic		Immediate Cause (Final disease or condition resulting in death) a. A C v to Myo Cq / dia) In tax	= 700		Interval Between Onset and Death			
		-	Due to (or as a consequence of): Equentially list conditions, if any, leading to immediate us to (ir is a consequence of):						
		o Be Completed by Physician/Medical Examiner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (if is a consequence of): c. Due to (or as a consequence of):						
68760,	ificate be g physicie as the bur		d						
D. Box	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 54 hours after death. The At hours after death. To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit.		IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		23d. Date of de Month	livery Day Year			
rds, P	w requires thet been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage Renal DISEGSE	co use contribute to the cause of death?					
Division of Vital Records, P.	The law re ate has bee page 2 sho		Dichetes	24a. Was an autopsy perform	24b. Were a prior to death?	utopsy findings available completion of cause of			
'Vita	ysicien: s certific director.		examiner? Hospital:	eath Check only one		cutu)			
ou o	ding Phy th. : After thi s funeral o	tlon; T	27. Manner of Death Statural 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 2 Accident Ac	28d. Describe how		olly)			
Divisi	or Atten after deal Directors In by the	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str. City or Town,	eet and Number or R State)	ural Roule Number,			
	To the Hospital or Attending Physicien: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one)	ce, and due to the car curred at the time, da	use(s) and manner as te and place, and due	s stated. e to the cause(s)			
	To the To the comp	ž	29b. Signature and title of certifier 29c. License number		d. Date signed (Mont				
,	. 0		African Physician DS1854 30. Name and address of person who completed chuse of denth (Item 23a) (Type, Print) Michiel Silverman 3001 South Hanover	_ JSP	Hembe!	9,2006			
	10	10	Michael Silverman 3001 South Hansver 31. Date filed (Month, Day, Year) SEP 0 6 2006 32. Registrar's Signature	Street	Baltino	rt 2/225			
	Sta Registr		SEP 0 6 2006						

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra 28073 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 9:32 PM PARRISH MARIE 03 06 E. K. 09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTI MORE N/A GOOD SAMARITAN HUSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | FEB. 9, 1921 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M XX MARYLAND Yrs. 214-12-4355 85 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10h. County 10c. City. Town or Location in than "neturel", or iteme 23s or 28s-f ehow the Medical Examiner must be notified at 1X Yes 2 No Directo BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? APT. 21239 U.S.A. 6401 LOCH RAVEN BLVD. 343 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. snt: If Item 27 Ie marked other than College (1-4or 5+) Elementary/Secondary (0-12) ADMINISTRATIVE 12 SECRETARIAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MARIE ESTHER FISHER CHARLES JOHN PARRISH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) CHARLES E. PARRISH/BROTHER 6831 BOSTON AVENUE, BALTIMORE, MARYLAND 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page Department of Importent: If eny injury or once. PARKWOOD CEMETERY 9/7/06 BALTIMORE, MARYLAND 21. Signature of Funeral State Licensee Address of Facility Address of Figure 1 NC. FUNERAL HOME CONKLING STREET, BALTO., MD. 21224 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MULTI ORGAN **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of deliven 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ ACIZAL 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has be lirector, page 2 s 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No After this c 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural To the Hospins...
within 24 hours after death.
To the Funerel Director: Aft 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RESUUO 3/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601, LOCH RAVEN BLUD GOOD SAMARYTAN HOSPITAL SANDEEP MAGOON MD -BALTIMCILE. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 2006

ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2006 28074 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Poller Month 1910 M Physician Hlexander /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Battimore Baltimore
If Under 1 Year If Under 24 Hrs. GBM(Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number Year) **Funeral** Months 1 M 2□ F DOCK GAL None Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10h County ir then "natural", or Items 23e or 28e-f show the Medical Examinar must be notified at 1 Yes 2 □ No Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23e or 2 any nijury or other traumatic avent, the Medical Experiment for a gonce. 4009 21216 arrison Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Whit ģ 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Apri unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10/4 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State (D. CE ZOX MUNICAS MATERIA * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Morkion, m 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESINATOM FAILURG Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner EXTREME Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospitel or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit NETERM and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? signed by the atte I be detached for 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 🗖 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ☐ Yes 2☐ No 1 Yes 2 No 25. Was case referred medical examiner? 26. Place of Death Check onli one director, Other: Hospital: 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No P 28c. Injury at Work? 28d. Describe how injury occurred After the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 🗌 Yes 2 No hours after death. 2 Accident within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide determined illed in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 021264 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLVA CAMBLU WILLAND USA~ MD. 21236 31. Date filed (Month, Day, Year) SEP 0 6 2006 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 1, 2006 Physician KAREN YVETTE PERRY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner GILCREST HOSPICE CENTER TOWSON BALTIMORE 8. Date of Birth 9-6-1961 Birthplace (State or Foreign Country)
 MARYLAND If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 TF Yrs. Director 213-86-4666 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show the Medical Examiner must be notified at 1 √ Yes 2 No Directo MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 808 N. WOODINGTON RD. 21229 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23s any injury or other traumatic event, Its Medies 5. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) **ESTHETICIAN** COSMETOLOGY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JUDITH MYRICK EDWARD PERRY ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDITH PERRY (MOTHER) 808 N. WOODINGTON RD. BALTIMORE, MARYLAND 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Dispositio 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other 3 Pemoval from State 5 Other (Specify) KING MEMORIAL PARK 9-7-2006 BALTIMORE, MARYLAND 21. Signatupud Service Licensen NATHAN D. HIBNER 2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) years /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Systother (Specify) No. p(p 1 ☐ Yes 2 👿 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death
1 Accident 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of s after dea. 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 焙 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Vietelor 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) COL DS8303 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h St Barrose N. Charks 6601 Agron CHAZURS. MO 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State Registrar 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006

		1 - For State of Maryland / Department of Registrar Cert 1. Decedent's Name (First, Middle, Last)	rtment of Health and M tificate of Death	ental Hygier Reg. N	
Physici /Medi Examir	cal	Sylvia Laverne Rawlings 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Month 09/02/2	Day Year
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 217-76-6937 1 M 2 XF 47 Yrs.	Lanham If Under 1 Year	8. Date of Birth (Month, Day, Yea 04/15/1	Prince Georges 9. Birthplace (State or Foreign Country) 959 Maryland
פ	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc MD Prince Georges Lanham	ation		10d. Inside City Limits 1
7.72 hours after death with the Maryland "natural", or Iteme 23e or 28e-f ehow sitical Examination man be invitted at	Funeral Director	10e. Street and Number 6822 Riverdale RD 11. Marital Status 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	10f. Zip Code 20706 Tas Decedent of Hispanic Origin? (Sperys, specify Cuban, Mexican, Puerto I		USA 14. Race - American Indian, Black, White, etc. Specify:
d within giene. r then	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Yes 2 No Specify: ent's Usual Occupation ind of work done during most of working O NOT use retired) Les Associate	ng	Kind of Business/Industry
d 2 should be filed h and Mental Hygin 7 Is marked other traumatic event,	To Be C	17. Father's Name (First, Middle, Last) Elijah Sewell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	18. Mother's Name Ruth C		
a a E E		20a. Method of Disposition 1 □ Donation 5 □ Other (Specify) 20b. Place of Dispos 20b. Place of Dispos 3 □ Removal from State Brooks: 4 □ Donation 5 □ Other (Specify)	mited (09/1	ate 20c.	Location - City or Town, State
permit. Pages 1 Department of H Important: If ite eny injury or ot once.		21. Signature of Funeral Service Licensee 22. Fu	Name and Address of Facility W. Wo neral Services nkirk, MD 2075	esley Ch 4INC.106	ayis III 84 Southern MD B
death certificate be executed /Medical Examiner e attending physicien and for use as the burial-transit	edical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Cancer of Lary Due to (or as a consequence of): Due to (or as a consequence of): c. Due to (or as a consequence of): Due to (or as a consequence of):	ynx		Interval Between Onset and Death 18 month
	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
law requires that the es been signed by th . 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 No 3 Probably 4 Unknow
The page	e Completed	25. Was case referred to medical	26. Place of Death	24a. Was an autopsy performed? 1 Yes 2 I	
anding Physiath. or: After this ne funeral di	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the t	edical Certiff	28a. Certifier (Check only 25 Studies determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify) 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or inventors.)	occurred at the time, date and place, a	City or Town, Sta	(s) and manner as stated.
To the H within 24 To the F complete	Medi	29b. Signature and title of certifier Cullen	29c. License number D0034714	29d. [Date signed (Month, Day, Year)
Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	ene St. Baltimo:		

		_	For State Registrar		Maryland	d / Depa	artmer rtifica	t of H	ealth a Death			Reg. No.	06	28077
	. Physicia	an	Decedent's Name (First, Middle, La								2. Date of De. Month	Day	Year	3. Time of Death
	/Medic	al	Margare 4a. Facility Name (If not institution, give	t Alma Sc			4h Ciby	Town or	Location of		Septeml		2006 inty of Deatl	12:45 A M
-	Examin	er	Holy Cross Nurs			nter			svill				ontgon	
1	Funeral		5. Social Security Number 6. 5	Sex 7.7	Age (In yrs. i			r 1 Year	If Under 2		8. Date of Bird (Month, Da	h	9. Birth	nplace (State or Foreign untry)
	Director		195-07-2887	1□м 20 F	90	Yrs.	Months	Days	riours		OCT 23,	1915		yland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Maryli feb	io	Maryland Baltin	more.			Ralt	imor	a					1 ☐ Yes 2 🕅 No
	r 28a	rec	10e. Street and Number	IOLE				Code				10g. Citizen	of What Co	untry?
	th with	Funeral Directo	5610 Gwynndale Av	venue					207				USA	
	r dea	ner	11. Marital Status	12. Was Deceder Armed Force 1 \(\text{Yes} \) 2	nt Ever in U. \$?	S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	spanic Orig n, Mexican	gin? (Spe i, Puerto F	cify Yes or No Rican, etc.)	14. [Race - Ame Black, White	rican Indian, a, etc.
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	1 ☐ Yes 2/1 If Yes, Give Year or Date:			1 🗆 Yes	2 ∑ №	Specify:			Spe	ecify:	White
8	2 hour	ed t	15. Decedent's E	ducation		16a. Dece	dent's Usi	al Occupa	ation			16b. Kind o	of Business/	
215	hin 72 9. Ne Jih	Completed	(Specify only highest gri	ade completed) College (1-4c	or 5+)	life.	DO NOT	ise retired	turing most)	t or workir	ig			
2	ygien ygien t, II.a	Con	12			Ste	enogr	aphe		ria Nama	(First, Middle		Busine	ess
ğ	be fill H of other	Be	17. Father's Name (First, Middle, Last George Wedra	")							Dietric		патеј	
Maryland 21215-0036	hould d Mei mark matic	ဥ	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Addres	s (Street a			l Route Numb		wn, State, 2	Zip Code)
Ma	nd 2 s lith an 27 is r trau		Eileen Joseph/Da			914	Pinc	t No	ir Wa	y W	indsor,	CA	95492	
Je,	ss 1 all of Heal item	ľ	20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 🖟		20b. P	lace of Dispo	osition (Na matory or	me of other plac	θ)	D	ate	20c. Locati	on - City or	Town, State
Ē	Page ment c ant: If ury or		4 □ Donation 5 □ Other (Speci		Met	ro Cr	emato	ry.	Inc.	9/6/0	06	Bal	timore	e, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, it a Medical Exercities must be notified at ance.		21. Signature of Funeral Service Lice	nsee		2:	2. Name a	nd Andres	s of Facilit	y Cre	mation	Socie	ty of	MD, Inc.
	0 0 = € Ø		C. Todd Dring		ad the death						Baltimo) 2122	Approximate
	38		shock, or heart failure. List only	one cause on each	ine.									Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Due to (or	as a consequ	VQLA(od	Del	uen	itio	2.0			
	Examiner		Conventially list and disings	b	·									
130	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):										
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a conseq	uence of):								
8760,	ate be executed hysicien and the burial-transit	ical E		-										
687	ilicate g phys as the			o										
Вох	death certifical e ettending phy id for use as th	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			⊒Ectopic	oregnancy				23d	Date of de	*
B	0 0 0	Physician/Med	in the past 12 months?	4□Pregnan 9□ Unknow	t at time of d		Other (s						Month	Day Year
P.O.	iaw requires that the de. as been signed by the e r 2 should be detached f	Phy	9 Unknown Part II, Dther significant conditions	contributing to deat	h but not res	ulting in the u	underivina	cause div	en in Part I		23e. Did	tobacco use	contribute to	the cause of death?
ds,	signe d be o	d by	, a			-	,,	•			10	Yes 2 N	lo 3 🗆 Pr	robably 4 DUnknown
Record	w require been sly should b	lete			· · · · · · · · · · · · · · · · · · ·						24a. Was	an 2	4b. Were at	utopsy findings available
Re	0 4 0	Completed									auto perf	ormed?	death?	completion of cause of 2 ☐ No
ital	ician: Th certificate ector, pag	BeC	25. Was case referred to medical						26. Place	e of Death	(Check only			
) \ \ \	Physician: rthis certifican ral director.	To	examiner? 1 Yes 2 No	Hospital: 1 🗆 Inp		ER/Outpatie	_		4 (92 191		me 5□Res			cify)
n c	ing P	on:	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	of M	28c. Injur Wor	yat k? Yes 2□		28d. Describe	how injury o	ccurred	
Division of Vital	if or Attending after death. Director: After d in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not determine	be gen Place of	Injury - At h	ome, farm, si			103 2				lumber or R	ural Route Number,
<u>≤</u>	affor affor	Certification:	4 Homicide	b <i>u</i> ilding	, etc. (Specit	(y)		,			City or To	wn, State)		
	To the Hospital or Attending i within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C		Physician: To the beaminer: On the basi	s of examina									
	To the h within 24 To the f complete	Me	29b. Signature and title of certifier	ران			2	9c. Licens	e number			29d. Date s	igned (Mon	th, Day, Year)
	1			P	,			D0054	4566			Septe	mber !	5, 2006
	1		30. Name and address of person who						D1	Sui	te 230	Тот	son,	MD 21286
70	- 01	ate	Sunitha Bhogavi. 31. Date filed (Month, Day, Year)	# 32. Rec	IZZU	A Ea	ast J	oppa	коаd		200	• 10W	30119	21200
	Regist		SEP 0 6 200	6 places	2 83	San Contraction of the Contracti	Sec.							

			For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment of F rtificate of a	lealth and N <i>Death</i>	lental Hygie Reg.	ne 2006	5 28078
	Physici /Medio		1. Decedent's Name (First, Middle, Last,	IE	R4.	TTA		2. Date of Death Month SEPTEMBE	Day Year R 03, 200	3. Time of Death 3:05 P M
	Examir		4a. Facility Name (If not institution, give The Hebrew Home				r Location of Death ville		4c. County of Dea Montgo	
	Funeral Director		0/1-32-7041	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min,	8. Date of Birth (Month, Day, Ye Aug. 05,	9. Bi	nthplace (State or Foreign ountry) Poland
	Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County MD Montgom		ity, Town or Lo Rockv					10d. Inside City Limits 1 ☐ Yes 2 💆 No
	th with the 23a or 28a	al Director	10e. Street and Number 6105 Montrose	Road		10f. Zip Code	852	10g.	Citizen of What C	ountry?
920	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel" or Iteme 23e or 28e-f ehow any figury or other traumatic event, the Medical Examinal must be nutilised at ODE.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in t Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: V	
Maryland 21215-0036	within 72 ho ane. then "natur he Madical	Be Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired emaker	during most of work	ing 161	Own H	·
land 2	lid be filed lental Hygie ked other ilc event, II	To Be Co	17. Father's Name (First, Middle, Last) Harry Oliver		HOM	emaker	18. Mother's Nam Rose Fi	e (First, Middle, Mai COST		One
	1 and 2 should Health and Men em 27 is marke ther traumatic	_	19a. Informant's Name/Relationship (T) Sheila Rutta Ca	terraccio/	631	18 Moun		al Route Number C est Driv	14.74	Zip Code) on Arizona
Baltimore,	ment of He tent: If iten jury or oth		20a. Method of Disposition 1	lenoval from State	Beth		em. 9/0	5/06 E		ew York
Ball	permit. Page Depertment: Importent: II eny injury o		21. Signature of Funeral Service Livens	el ') P	HITIPAD 241 Col	SRINALD: umbia B	I FUNERA lvd.Silv	L SERVI er Spri	CE,P.A. ng,Md20910
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)		MON		ig, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner	er		Due to (or as a conse	ESTI	VE HE	MRIFI	AILUR	E	
	ficate be executed physicien end	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
68760	ficate be executed physiclen end	edical E		d						
P.O. Box 6	ath certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregr 1□Live birth 2□Fet 4□Pregnant at time of 9□Unknown	al death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	blivery Day Year
	quires that the de n signed by the e uld be detached f		Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tobac	1/	o the cause of death? Probably 4 []Unknown
Vital Records,	The law requir ate has been si page 2 should I	Completed by						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of s
	siclan: certific irector,	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐	TER/Outpation	at 3□ DOA Oth	/	th Check only one	- 6 DOther (C-	-0.63
n of	Attending Physician: r death. sctor: After this certific by the funeral director, i	lon: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe how		эспу)
Division of	or Attend after death Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec			Yes 2 No	28f. Location (Stree City or Town, S	t and Number or Fitate)	Rural Route Number,
_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	233 Certifier 112 Cartifying Phy (Check only one) 2 Medical Exami	sician. To the best of my kn ner: On the basis of examin and manner stated.	iowledge death ation and/or in	n continued at the time vestigation, in my o	ne, date and place pinion, death occur	and due to the caus red at the time, date	e(t) and manner a and place, and du	e to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier Baubauce	Kolas	ug M.	29c. Licens	е питьег 3543	6 SE1	Date signed (Mon	1th, Day, Year) 203, 2006,
	b		30. Name and address of person who co	NY M.D. 612	21 HOW	Print) TROSER	080,00	deville	E, MD	203, 2006.
	Sta Registi		31. Date filed (Month, Day, Year) SEP 0 6 2006	32. Registrar's Sign	nature for	de la company de				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** August : 39 pM Arion Robinson 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltinore
If Under 1 Year | If Under 24 Hrs. JEwwe Hosi tal 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 77-68-6172 1950 Director WASHINGTON, DC Usual Residence of Decedent the Maryland 10a. State Od. Inside City Limits 10b. County 10c. City, Town or Location r then "neturel", or items 23s or 28s-f ehow the Medical Examiner must be notified at MARYLAND PRINCE GEORGES
10e. Street and Number 1 Yes 2 No Directo OXON HILL 10f. Zip Code 10g. Citizen of What Country? Spokane 5803 20745 U.S. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status filed within 72 hours after 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black þ Specify: Specify: 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 9-12College (1-4or 5+) Department of Health and Mental Hygiene. Important: (I Item 27 is marked other ther any injury or other treumstic event, ILE MODE. Administrative AssistantFederal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Pearl Hollev William E. Suydan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Robinson (son) 3324 6th St. S.E., Washington, DC 20033 20a. Method of Disposition

✓ Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 8-17-2006 Brentwood, MD Lincoln 21. Signature of Funeral Service Lightsee permit. 22. Name and Address of Facility Reese Professional Funeral Service-3605 14th St.NW, Washungton, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) the Ecoscherotic Physician HEARL /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infiniediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of). Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical use as ettending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon 5 Other (specify) signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 4 MUHKhown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 BHO 25. Was case referred to medical Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 Certification: To 1 ☐ Yes 1 🗌 Inpatient 2 CF Outpatient 3□ DOA şi. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the hours after death 6 Could not be determined 3 Suicide in by 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours at To the Funerel D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examilities: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) BR7794832 Bygust 7, 2000 MO ne and address of person who completed cause of death (Item 23a) (Type, Print) 2008 WEST Baltimore Street Bestinger ROBI NJON MD ARLEN E

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

The law requires that the death certificate be executed Box 68760. Division of Vital Records, P.O. or Attending Physicien: 28a-f show

buld be filed within 72 hours after Mental Hygiene.

Heelth tem 27

Page 1

nding physicien

Baltimore, Maryland 21215-0036

within 24 hours a To the Funeral I completely filled

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

JAMES TANSINOA



AMENDING

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

10056948

29d. Date signed (Month, Day, Year)

31

AVG

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 8859 9-6-06 vt. State of Maryland 7 Department of Health and Mental Hygiene 0 0 0 006 1 - For State Registrar 28081 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear 06 **Physician** Antoinette 10:00 AM Russell September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Maryland Medical Center 10 If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M 2 2 9 Yrs. Director August 13 1937 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show amy injury or other traumatic event, The Medical Examiner must be multilised at once. 1 Pres 2 No Funeral Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21009 526 Was Decedent Ever in U.S Armed Forces? 1 Yes 2 146 Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Yes 1 Never Married 2 Married 1 ☐ Yes 2 ₺ No Baltimore, Maryland 21215-0036 Yes, Give Year or Dates: Specify Specify. þ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 13 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 MOY 19a. Info ant's Name/Relationship (Typ , Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 husband 20c. Lection - City or Town, State June 1 John 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation _5 ☐ Other (Specify) remotor) 21. Signature of uneral Service Licensee 22. Name and Address / Facility AM1232 Midvalley Dr. Dessue Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock Immediate Cause (Final disease or condition resulting in death) **Physician** barachnoid /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physician; The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 moetris?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ò Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case relerred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 Yes 2 No death. М 2 Accident completely filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number Employee 10# 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

5

Daymont

Pratt

17368

Baltomore MD 21201

Molly

19

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Molly Daymont
31. Date liled (Month, Day, Year)

SEP 0 6 2006

Physician /Medical Examiner

1 - For State Registrar			of Marylar		artment o	f Health a of Death	ind Me		ene g. No.	006	28082
1. Decedent's Name							2	2. Date of Death	_ Day	Year	3. Time of Death
		RICHTER						AUGUS	T	2006	7:30P M
4a. Facility Name (If I			mber)			m, or Location of	f Death			ounty of Death	_
5. Social Security Nu		6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye		4 Hrs. 8	3. Date of Birth		9. Birth	place (State or Foreign
212~40~04! Usual Residence of D	53	1 X □M 2□F	91	Yrs.	Months Da	ays Hours	Min.	(Month, Day, April S	9, 19	Cou	yland
10a. State	10b. County		10c. Ci	ity, Town or Lo	cation						10d. Inside City Limits
Maryland 10e. Street and Number	Balti	more		Ba	ltimore	County			A Citiza	n of What Cou	1 ☐ Yes 2 ☐ No
800 South		d.				1286			US <i>F</i>		may:
11. Marital Status		12. Was Dec Armed For ied 1 Tes	edent Ever in U	J.S. 13.	Was Decedent If Yes, specify (of Hispanic Origi Cuban, Mexican,	in? (Speci Puerto Ri	ify Yes or No- ican, etc.)	14.	Race - Amer Black, White	
1 ☐ Never Marrie 3 ☐ Widowed 4		ied 1 Tes If Yes, Gi Year or D	2≹ No ve Dates:	j	1 ☐ Yes 2★☐				Sp	_{pecify:} Whi	
(Specifi	15. Decedent by only highes	t grade completed)	1-4or 5+)	16a. Dece (Give life.	dent's Usual Od kind of work do DO NOT use re	ecupation one during most (stired)	of working	7	6b. Kind	of Business/Ir	ndustry
12 yrs.	idary (U-12)	9 yrs.	•	OBGY	N			(Self-	-Employ	ed ed
17. Father's Name (F	First, Middle, i	Last)				1		First, Middle, N	laiden Su	mame)	
Christian	F. Ri	chter				Ann	a Sch	nneider			
19a. Informant's Nan						reet and Number			-		
Corinne M		ter (Wife	·	_		ly Rd.			/lary]	Land 2	21286
20a. Method of Dispo 1 ☐ Burial 2 X☐ `4 ☐ Donation 5	Cremation	3 ☐Removal from	State	cemetery, crei	sition (Name o natory or other	place)	9~5~2	46		tion - City or T	
21. Signature of Fund			Met		matory, Name and Ac	ddress of Facility				lmore, air Rd.	
Malho	2 Sho	2-1-0	And and			uneral				. Md.	
23a. Part1. Enter the	e di ea e, or	complications that	used the dear	th. Do not ent	er the mode of	dying, such as c	ardiac or i				Approximate
shock, or heart Immediate Cause (F	failure. List	only one cause on	each line.	1 1	0-		0	4			Interval Between Onset and Death
disease or condition resulting in death)		a	(or as a nsec	way	plan	w Sy	ngh	rone			Lyon
		1 Due to	C P.	querice ory.	· An	em.					luv.
Sequentially list cond if any, leading to imm cause. Enter Underh	ditions, nediate	b. Due to	(or as a consec	quence of):	7,						- 1 /
that initiated events	njury	c									
resulting in death) La	ast	Due to	(or as a consec	quence of):						19	
		d									
IF FEMALE:											
23b. Was decedent p in the past 12 m 1 \(\text{Yes} \) 2 \(\text{D} \)	nonths?	1 Live I	tcome of pregnation of the community of	aldeath 3	Ectopic pregna Other (specify				23d	Date of delive Month	ery Day Year
9 Unknown											
Part II. Other signific	cant conditio	ns contributing to d	eath but not res	sulting in the u	nderlying cause	given in Part I.		23e. Did tob	_		the cause of death? bably 4 Unknown
								24a. Was an	2	4b. Were auto	opsy findings available
								autopsy	ed2	prior to co death?	ompletion of cause of
25. Was case referre	ed to medical					26 Place o	of Death /	1 Yes 2 Check only one	No	1 🗆 Yes	2 □ No
examiner?	6	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA	Othor	sing Home			Other (Speci	fv)
27. Manner of Dealin	5 Pending	28a. Date (Mon		28b. Time of Injury	28c. i	njury at Work? 1 🗆 Yes 2 🗆 Ne	28	d. Describe hor			97
2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investig 6 Could n determi	not be 28e. Place	of Injury - At h	ome, farm, str fy)				f. Location (Str. City or Town,		lumber or Run	al Route Number,
	/										
29a. Certifier (Check only 2	Certifying Medical E	g Physician: To the Examiner: On the b and man	e best of my kno easis of examina ner stated.	owledge, death ation and/or in	n occurred at the vestigation, in n	e time, date and ny opinion, death	l place, an n occurred	d due to the car at the time, da	use(s) an le and pla	d manner as s ace, and due t	stated. o the cause(s)
29b. Signature and til	itle of certifier				29c. Lic	ense number		29	d. Date s	ign g d (Month,	Day, Year)
	11	1m	ph	451 Co	\sim)29	76	9	9	1110	6
30. Tame and a dres	s of person v	ho completed cau	se of death (Ite)	23a) (Type,	5 (6N	-polli	no	BY VA	en ly	6 and	2/228
31. Date filed (Month	Day Year)	2006	legistrar's Signa	ature	and I		Ø		<i>√. ∨</i>		

DHMH 17 Rev 1/2001

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State Registrar

			State of Maryland / Dep	artment of Health and I	viental Hyg	•	28083				
	Physici /Medic		Decedent's Name (First, Middle, Last) ESTHER MAE ROBINSON		2. Date of Deat Month SEPT.	^{Day} 2006	3. Time of Death 9:15A M				
	Examin		4a. Facility Name (If not institution, give street and number) IVY HALL N. H.	4b. City, Town, or Location of Death MIDDLE RIVER		4c. County of Death BALTIMOR					
Ŀ	Funeral Director		5. Social Security Number 6. Sex 1 M XX F 7. Age (In yrs. last birthday 92 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Mar. 17	,1914 Mary	lace (State or Foreign try) land				
	within 72 hours after death with tha Maryland ene. than "natural", or Itams 23a or 28a-1 show the Medical Exami ar must be notified at	by Funeral Director	10e. Street and Number 5746 Cedonia Avenue	ocation altimore City 10f. Zip Code 21206 Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puert		0g. Citizen of What Cour USA 14. Race - Americ Black, White,	an Indian,				
2-0036	72 hours after natural', or Ita iical Examina	eted by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:			ite				
Maryland 21215-0036	should be filed and Mental Hygi s markad other umatic event, I	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of wor DO NOT use retired) etary 18. Mother's Nan	ne (First, Middle, I	Employment					
rylan		To Be	Henry Gerstmyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	Ella Ma	ay Adams	City or Town State Zin	Code)				
			Jacqueline E. Nolan (Daughter) 841	4 Allison Lane Bal	Ltimore,						
Baltimore,	parmit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or othar tra once.		'4 Donation 5 Other (Specify) Parkwoo		-2006	Baltimore,	Md.				
Bal	parmi Depar Impor any ir		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassann Funeral 7401 Belair Rd. Baltimore, Md. 21236								
	Medical Examiner	cal Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter of contyning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	nter the mode of dying, such as cardiac		est,	Approximate Interval Between Onset and Death				
P.O. Box 68760,				□Ectopic pregnancy □ Other (specify)		23d. Date of deliver	ery Day Year				
Records,	e lav has	Completed by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the Pre-Deletic 2 Chrone ASCUD, Pre-Di	underlying cause given in Part I. Are alich C	1 ☐ Ye 24a. Was a autops perform	an 24b. Were auto					
of Vital	sician: The sectificate lirector, pag	To Be C	25. Was case referred to medical examiner? 1 Yes		ith (Check only on						
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Medical Certification: T	27. Manney of Death 1 Polatural 5 Pending investigation 3 Suicide 6 Could not be determined 1 Phonicide 28a. Date of Injury (Month, Day Year) 28b. Time Injury 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, farm, so building, etc. (Specify)	of 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe ho	ow injury occurred treet and Number or Rura					
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	dical Co	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, dea (Check only one) 29 Medical Examiner: On the basis of examination and/or in and manner stated.	ath occurred at the time, date and place overstigation, in my opinion, death occurred.	, and due to the carred at the time, d	ause(s) and manner as s late and place, and due to	tated. the cause(s)				
)	To the within To the comple	Me	29b. Signature and title of certifier M. D	29c. License number D-3875	4 (2006				
	5		30. Name and address of person who completed cause of death (Item 23a) (Type MALLA DASEAM TO 9.	BASTERN P	LVD.	MD-21	221.				
Di	Regist	- 10	31. Date filed (Mohim Day, Year) 32. Registrar's Signature	and)							
יוט	IMH 17 Rev 1/2	.001	ORIGIN	IAL							

06-06552

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Ashley Rosenthal 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day September 1, 2006 ROSENTHAL 1618 hrs **ASHLEY** BETH Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Columbia 95 North at Route 100 If Under 24Hrs. Date of Birth(MM/DD/YYYY 9. Birthplace (State or If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 10/12/1982 Director MD 220-11-6370 2 X F 23 Country 1 M Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Yes 2 X No or 28a-f show ELLICOTT CITY MD HOWARD fied at once hours after death with the Maryland Director 10g. Citizen of What Country' 10e. Street and Number 21042 USA 3119 NESTLING PINE COURT or items 23a or must be notifi 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes 2 X No Yes, Give Year Yes 2 X No specify. WHITE Widowed Divorced ģ 16a Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4 or 5+) th and Mental Hygiene n 27 is marked other than "n aumatic event, the Medical E 72.1 Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other that injury or other traumatic event, the Medica MEDICAL BILLING **BOOKKEEPER** 2 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LESLIE SHOEMAKER ROSENTHAL Be JAY Н. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 3119 NESTLING PINE COURT - ELLICOTT CITY 21042 JAY ROSENTHAL / FATHER 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State CRESTLAWN MEMORIAL GARDENS 9/5/06 MARRIOTTSVILLE, MD 4 Donation 5 Other Specify. 22 Name and Address of Facility 21 Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. Levin. 8900 REISTERSTOWN ROAD - PIKESVILLE MD 21208 Matt 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last put Physician/Medical UNPENDED **AMENDED** Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy phy the l 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 ✓ No 3 Probably 4 Completed Division of Vital Records, 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy has l performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No certificate page ospital or Attending Physician: hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 🗸 Other: Scene this 1 🗸 Yes 28b. Time of Injury 28c. Injury at Work 28d Describe how injury occurred 28a Date of Injury After 27. Manner of Death on: Sep 1, 2006 Subject jumped from bridge Natural Yes 2 V No Pendina Director: the Certificat Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 🗸 Suicide Could not be 24 hours a determined (Specify) Interstate/Express 95 North at Route 100, Columbia, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of certifie O.C.M.E. September 2, 2006 30. Name and address of person who completed cause of death (Item 23a) Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Jack Titus MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 6 2006 Registrar

			For State Registrar	State of Ma	•	•	ent of He		•		106	28085
			Decedent's Name (First, Middle, Last)				ato or b		2, Date of De		,00	3. Time of Death
	Physici		Thomas Robinson						Month	+ Bay	200/a	1200AM
	/Medic Examir		4a Facility Name (If not institution give s	treet and number)	ospital	1 B	City, Town, or L	ocation of Deat	ity	4c. Count	y of Death	
	Funeral Director		210-30-0402	M 2□F 7. Age	e (In Frs. last birti 73 Y	hday) If Ur Moni	ths Days	if Under 24 Hrs Hours Min.	8. Date of Bit (Month, Da Oct 19	ıy, Year)	Cour	lace (State or Foreign http) yland
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					1	0d. Inside City Limits
	Mary -f •hc	ğ	MD		Baltimo	re						1 Yes 2 □ No
	28a	Tec	10e. Street and Number				. Zip Code			10g. Citizen of	What Cour	itry?
\sim	3a o	Funeral Director	11 West 20th Stree	t 16L			212	18		US	Δ	
7	death	ner	11. Marital Status	2. Was Decedent I Armed Forces?	Ever in U.S.	13. Was D			pecify Yes or No to Rican, etc.)		ce - Americ	
06,700V	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiane. Important: if Item 27 is marked other then "netural", or Items 23a or 28a-f ehow with injury or other traumatic event, I'm Mealical Exeminar roual its rigiting at anone.	by	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 XI If Yes, Give Year or Dates:	No		s 2 No	Specify:	o nican, etc.)	Speci	ick, White, <i>fy:</i> W	hite
2-0	netur	Completed	15. Decedent's Educ (Specify only highest grade				Jsual Occupat	ion iring most of wo	rkina	16b. Kind of E	Business/In	dustry
5	within ane. then "	ğ	Elementary/Secondary (0-12)	College (1-4or 5		`life. DO NO	T use retired)		•			
200	Hygia Hygia Sthert		12 17. Father's Name (First, Middle, Last)	0		carp	enter	19 Mothods No.	ne (First, Middle	self		yed
\mathcal{MS} \mathcal{K}	ntal H	Be	Charles Robinson						•	, Maiden Suma	тө)	
~ \ \	should ind Men inarke umarfic	은	19a. Informant's Name/Relationship (Typ	na Print)	19h	Mailing Add	ross (Street ar	Alice]	Jecker Jral Route Numb	er City or Town	State Zin	Code
Ma	od 2 s Ith an 27 is trau		Sally G. Robinson			979 D. 201	10000 90					× 22
Je,	s 1 ar i Hea item 3		20a. Method of Disposition	•	20b. Place of	Disposition i	Name of		6L Balt Date	20c. Location		
200	Pages nent of int: if I		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☑ Donation 5 ☐ Other (Specify)	amoval from State	cemetery	r, crematory	or other place,	'				
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			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that eaused	the death. Do n				or respiratory a	rrest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as	a consequence o	f):	41001		-			
		16	Sequentially list conditions, b	HVDOV	a c nsequence o	i U						
	nsit	Examiner	if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury	10 (0. 20	a o 1110quo1100 o	-,-						
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8760,	cate be ex physicien the buria	dlcal	٥									
9		(I)	15.55.00.5				_					
Xox	th cer tendir r use	lan/Me	230. Was decedent pregnant	3c. If yes, outcome 1 ☐ Live birth	of pregnancy 2 Petal death	3 □Ectop	ic pregnancy				ate of delive	*
). E	e dea the at ned fo	<u>U</u>	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 Cher	(specify)			M	onth	Day Year
P.(that the death certifii ed by the attending p detached for use as	by Phys	Part II. Other significant conditions con	tributing to death by	ut not resulting in	the underhi	na cauca aivar	in Part I	23e Did 1	obacco use con	stribute to th	ne cause of death?
ds,	Attending Physician: The law requires that the death certifi rideath. sctor: Atter this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	d by		and and a document	at not rosatting in	the dideliya	ng cause give	1 11 1 21 (1.		Yes 2□No	3 ☐ Prob	
Š	w requires been sign should be	ete							24a. Was	20 24h	Mora auto	nou findings qualishle
Re	he lay e has	Completed							auto perfe	rmed?	death?	psy findings available mpletion of cause of
tal	ysician: The l is certificate he director, page	0	25. Was case referred to medical	· · · · · · · · · · · · · · · · · · ·				26 Place of De	1 Yes ath (Check only		1 🗌 Yes	2 No -
<u> </u>	ysici is cer direc	0 8	examiner?	ospital: 1 Inpatie	nt 2 ER/Out	patient 3	DOA Other		łome 5 ☐ Resi		her (Specifi	()
0	ding Phys	T :uc	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injui	ry 28b. Ti		28c. Injury a			how injury occu		·
.0	vttendir death. ctor: Af y the fu	atlo	2 Accident investigation			M		es 2 □No				
Division of Vital Records, P.O. Box	s after de safter de al Direct	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, far c. (Specify)	m, street, fac	ctory, office		28f. Location (City or To		ber or Rura	l Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 **Def Certifying Physics** 2 **Medical Examination**	ician: To the best of er: On the basis of and manner sta	examination and	death occur Vor investiga	red at the time tion, in my opi	, date and place nion, death occu	a, and due to the urred at the time,	cause(s) and m date and place,	anner as si and due to	ated. the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier				29c. License	number	FITA	29d. Date signe	ed (Month,	Day, Year)
) . C . 3	3				84	2/2	AUGUS	St 2	7,200Co
			30. Name and address of person who con	inpleted cause of d	eath (Item 23a) (Type, Print)	nr. 11	and la	PINAIN	al Unc	n.Ln	/
	Sta	to	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	0110	40414	IIII (C11776	11/703/	114	/
*	Registr		SEP 0 6 2006	Ele we	15 1	poste	1					

06-06544 Please Type or Print in Black Indelible Ink Vernon Smith State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No. Registrar ent's Name (First, Middle, ast) 2. Date of Death Physician/ Month Day September 1, **Medical Examiner** 2006 10 U street and number) 4a Facility Name (if not institution, 4b. City, Town, or Location of Death 4c. County of Death Owings Mills 10 Enchanted Hills Road **Baltimore County** 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Min Days Hours Director 20-07-29 M 2 Yrs Usual Residence of Decedent Au. 10b County 10c. City. Town or Location other than "natural", or items 23a or 28a-f show the Medi al Examiner must be notified at once. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e. St 10g Citizen of What Co Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever Armed Forces?

1 Yes 2 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Yes, Give Year Yes 2 No specify 3 Widowed 4 Divorced ⋛ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) pleted Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical MD 21215-0036 orema Com Father's Name (First Middle, Las Be 19b. Mailing Addr 20a Method of Disposition Itimore, 2 Cremation Burial 3 Removal from State 9 Other Specify ice Lic ter the disease, or complications that caused the death. Do not enter the mode of dying, suct as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. /Medica a. Gunshot Wound to Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical UNPENDED AMENDED attending physician for use as the burial Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate by IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown icate has been signed by the page 2 should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy After this certificate has performed' Yes 2 26.Place of Death (Check only one) funeral director, 25. Was case referred to medica Be Other₄ Inpatient ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other. Scene 1 V Yes 28a. Date of Injury (Month Day, Year) FOUND: 28d. Describe how injury occurred Manner of Death 28b. Time of Injury 28c. Injury at Work? 27. Certification: Subject shot self **FOUND** Natural Pendina Yes 2 V No filled in by the Sep 1, 2006 0923 hrs Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be

(Specify) Multi-Family Apt.

and manner stated

Assistant Medical Examiner

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

0935 hrs

10d Inside City Limits

1 Yes 2 No

Approximate Interval

Between Onset and

Death

Year

Day

death?

10 Enchanted Hills Road, Owings Mills, MD

September 2, 2006

29d. Date signed (Month, Day, Year)

prior to completion of cause of

American Indian, Black,

oreign

24 hours after death

To the Funeral Director:

State Registrar

OCME 2006

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

O.C.M.E

111 Penn Street, Baltimore, MD 21201

Medical

one)

Homicide 29a. Certifier 1

29b. Signature and title of

Melissa Brassell, MD 31 Date filed (Month, Day, Year)

			1- State of Maryland / Dep	artment of Health and Mertificate of Death	lental Hygie	7000 20007					
7		•	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death					
	Physici /Medic		John T. Senkewic		AUGUST 3	18 2006 10:40 A M					
1	Examin	ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	•	4c. County of Death					
	Famous		St. Agnes Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Baltimore Honder 1 Year Honder 24 Hrs.	8. Date of Birth	N/A 9. Birthplace (State or Foreign					
	Funeral Director		218-48-0436 XDM 2DF 59 Yrs.	Months Days Hours Min.	(Month, Day, Ye 05/16/19	ear) Country)					
	pu .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or U	ocation		10d. Inside City Limits					
	Manyla f sho	ro		ore City		¥∑Yes 2 □ No					
	r 28a	Funeral Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?					
	th with	alD	2046 Harman Avenue	21230	τ	United States					
	tams	nue	11. Marital Status 12. Was Decedent Ever in U.S. Ammed Forces?	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.					
336	be filed within 72 hours after death with the Maryland that Hygiene. d other than *natural', or Itams 23a or 28a-f show avant, I're Medical Examinat must be mullified at	by F	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: White					
200	72 hou	ted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	166	b. Kind of Business/Industry					
121	vithin ne. han r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	mg						
2			12 N/A Pro	oject Manager	e (First, Middle, Maid	Cable Company					
lan	ould be f Mental barkad of arkad of atic ava	To Be	Walter T. Senkewic		ta May Fla						
Maryland 21215-0036	s 1 and 2 should be filed I Health and Mental Hygi Itam 27 Is markad othar othar traumatic avant, I	-		ing Address (Street and Number or Rura	al Route Number, Ci	ity or Town, State, Zip Code)					
Σ,	r t t			Harman Avenue, Bal							
ore	00		1 Peuria: 2 Cremation 3 Hemoval from State	matory or other place)		. Location - City or Town, State					
Baltimore,				Veterans 09/01	1/2006 Cr	cownsville, Maryland					
Ba	permit. Departr Importa any inji		Lind Sind	2. Name and Address of Facility Huk 4107 Wilkens Avenu	obard fune we, Baltim	eral Home, Inc. Nore, Maryland 21229					
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	Approximate Interval Between							
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Acute branchopneumon (I) Due to (vise a consequence of I)								
	/Medical Examiner		Due to (or as a consequence of):	,							
	*	Jer	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
30.	acuted and transii	Examiner	that initiated events								
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit		Due to (or as a consequence of):								
687	fficate g phys	edical	d								
Вох	eath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	Ectopic pregnancy		23d. Date of delivery					
	at the deal by the att tached fo	Physician/Me		Other (specify)		Month Day Year					
P.0	that the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobace	co use contribute to the cause of death?					
Vital Records,	n signe	ed by	Atheroscleratic Coronary art	ery Disease	1 🗋 Yes	2 □ No 3 □ Probably 4 🕱 Ūnknown					
900	aw requisite been 2 should	Completed	hypertrophic Candiomyopa	thy.	24a. Was an	24b. Were autopsy findings available prior to completion of cause of					
E E		Com			autopsy performed 1/ X Yes 2 □	l? death?					
Vita	Physician: T r this certificate ral director, pa	Be	25. Was case referred to medical		(Check only one)						
of		1: To	1 Yes 2 No		me 5 Residence 28d. Describe how in	e 6 □Other (Specify)					
ion	Attending F death. ctor: After y the funer	atior	1 ≸ Natural 5 □ Pending (Month, Ďaý Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		.,(-,)					
Division	after death after death Diractor: I in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Stree: City or Town, Si	t and Number or Rural Route Number, tate)					
	oital o urs afi aral Di										
	To the Hospital or Attending within 24 hours after death. To the Funaral Director: Afte completely filled in by the fune	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)					
	To the P within 2- To the P complet	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)					
•	, \		MD, PhD	D0037359	A	19UST 29, 2006					
	10X1		30. Name and address of death (Item 23a) (Type	Print)	n - 1	Billian Manager					
	Sta	te	31. Date filed (Month, Day, Year) 32. Magistrar's Signatura	105 pila 1 - 400 (210	17 HUENUE	Baltimore, mo 21229					
y-	Registr		SEP 0 6 2006 32. Hegistrar's Signature 32. Hegistrar's Signature 32.								

Amend #8 Per FH 8859 9/08/06 JH Department of Health and Mental Hygiene 2006 Registrer Amend Items 10a-10f, 26 per FH/Dr. 6859 (9/06/06dhb Registrer Amend Item#7, perFH, 6859, 9/11/06 TT Certificate of Death Reg. No. 28088 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 26, 2006 **Physician** SALTZMAN DAVID 3:35 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 257 SHEEPSKIN DRIVE WESTMINSTER CARROLL 812 ia 25 in 1919 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours Min PA 087-01-4478 87 86 Yrs. Director Usuat Residence of Decedent death with the Maryland 10a. State NY 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Sullivan Smallwood digal Examiner must be notified at CARROLL 1 ☐ Yes 2 X No Be Completed by Funeral Director 10e. Street and Number Pocohontas Trail 12778 10f. Zip Code 10g, Citizen of What Country? 257 SHEEPSKIN DRIVE-21157 USA Iteme 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Depertment of Health and Mental Hygiene. Important: if Item 27 Ie marked other then "naturel", or Item any injury or other traumatic event, the Medical Exempted ORDE. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No WHITE Specify: Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SIGN HANGER SIGNS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GIBSON SALTZMAN ANNA PETER ္ဝ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) POCOHONTAS TRAIL - SMALLWOOD, NY 12778 MARILYN SALTZMAN / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 🛱 Burjal 2 ☐ Cremation 3 X Removal from State BETH DAVID CEMETERY 8/29/2006 ELMONT, NY 5 Other (Specify) turn f Funeral/Service Live 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part f. Enter the disease, or complications that so sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each tine. Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** ANCREATIC MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. ettending physiclen Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 21XN0 1 Yes 1 Yes certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Shesidence 6 NOther (Specify) Residence Hospital: 1 | Inpatient 1 ☐ Yes 2X No ٩ 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 5 Pending investigation naral Director: A death. 1 Tes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Roule Number, City or Town, State) 4 | Homicide within 24 hours of To the Funaral I 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, reath socured at the time, date and place, and due to the cauca(e) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 6 eted cause of death (Item 23a) Type, Print) 30. Name and address of person who comp CHRISTIAN FREDERICK MEYER, 5209 DOWNING ROAD, BALTIMORE, MARYLAND 2012 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 6 2006 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2006 28089 Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Day 29 Year 20de 4:50AM STAWARA Physician, ROBERT AUGUST /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** JUHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1X M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Yrs. 219-38-6625 Director -3 - 1939Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a State 10b. County 10c. City, Town or Location ral', or iteme 23a or 28a-f ehov Examiner must be notified at 1 Yes 2 No Director MD Baltimore City 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if I tem 27 is marked other then "--- ery injury or other traums". 3738 Mt. Pleasant Avenue 21224 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: White Specify ģ 3 ☐ Widowed 4 N Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Stawara Loretta Rostkowski ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pamela Stawara - Daughter 3738 Mt. Pleasant Ave, Baltimore, MD 21224 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Bayview Crematory 9-6-06 Baltimore, MD 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licensee PA, 2134 Willow Spring Rd., 21222

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate Interval Between Conset and Death Cons & END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): 68760, Box IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Dav Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cete has been signed pege 2 should be de Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 215 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No after deeth. investigation 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie AUGUST 29, 2006 RES OOL llloh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEIRDRE FOSTER JOHNS HOPKINS BAYVIEW MEDICAL CENTER 4940 EASTERN AVE. BALTIMORE, MD 21224 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 6 2006 Registrar

DHMH 17 Rev 1/2001

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# 3		1 - State Registrar 1. Decedent's Name (First, Middle, Last)	/ Department of Health and I Certificate of Death	Reg. No 2006 2809 2. Date of Death 3. Time of Death					
Physicia /Medic	al	Thomas Raymond Schoenauer	4b. City, Town, or Location of Death	Month Day Year O 7:41 A					
Examin	er	4a. Facility Name (If not institution, give street and number) GDOD SAMARITAN HOSPI							
Funeral Director		5. Social Security Number 188-52-8419 1	st birthday) If Under 1 Year If Under 24 Hrs. Yrs. Months Days Hours Min.	8. Date of Birth May 18, 1958 9. Birthplace (State or Foreign Country) Pennsylvania					
yland		10a. State 10b. County 10c. City,	Town or Location	10d. Inside City Limit					
Ba-1 el	ector		imore	1 X Yes 2 ☐ N					
3a or 3	i Di	3205 Bayonne Avenue	21214	USA					
rs after deatl	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Widowed 4 Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White					
natural	ted !	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of wor	16b. Kind of Business/Industry					
within 7	Completed	Flomentary/Secondary (0.12) College (1.4or 5+)	(Give kind of work done during most of wor life. DO NOT use retired) Sales Engineer & Project Mal						
ild be filed v lental Hygie rked other iic event, II	To Be Co	17. Father's Name (First, Middle, Last) Francis C. Schoenauer	18. Mother's Nar	ne (First, Middle, Maiden Sumame) leen Gallen					
2 shou and N ie mai		19a. Informant's Name/Relationship (Type, Print)		ural Route Number, City or Town, State, Zip Code)					
permit. Pages 1 end 2 should be liled within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If term 27 is marked other than "natural", or iteme 23a or 28a-1 ehow eny injury or other traumatic event, I'm Medical Exercitors investigate in clitted at once.		_ cei	3205 Bayonne Avenue Balt ace of Disposition (Name of metery, crematory or other place) lonn the Baptist Cem. 9/9	Date 20c. Location - City or Town, State					
permit. P Departme importan eny injur.		21. Signature of Funeral Service Licensee Chustina L. Natton	Leonard J. Ruck, Inc. 5305 Harford Road Bal	timore Maryland 21214					
sicien and surial-transit	ai Examiner	Sequentially list curultions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence	ence of):	TO END STAGE LIVER DISEASE					
thet the death certificate ed by the attending phy: detached for use as the	by Physician/Medica	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not result.	death 3 □Ectopic pregnancy ath 5 □ Other (specify)	23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death?					
Physicien: The law requires this certificate has been sign at director, page 2 should be	Completed b			24a. Was an autopsy performed? 1 Yes 12 Ho 1 Yes 2 No 3 Probably 4 Horizon 24b. Were autopsy findings availa prior to completion of cause of death? 1 Yes 2 No					
Physicien: this certifice ral director, p	Be	25. Was case referred to medical examiner?	Other	ath (Check only one)					
uner uner	ation: To	1 Yes 2 Mo	28b. Time of 28c. Injury at Work?	Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred					
To the Hospitel or Attendi within 24 hours after death To the Funerel Director: A completely filled in by the fi	Certification:	6 Could not be	ne, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Hospi 24 hour Funer etely fills	edical	one) and manner stated.	on and/or investigation, in my opinion, death occ	urred at the time, date and place, and due to the cause(s)					
를 다 를	Σ	29b. Signafule and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PES 000 9/5/06							
To the within To the compl		30. Name and address of person who completed cause of death (Item RENU GUPTA GOOD SAMARITA)	, , ,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 28091 State of Maryland / Department of Health and Mental Hygiene? 11 16 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Richard Edward Smith September 2, 2006 4:49 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Hours Min Director 220-40-1873 18, 1942 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 28a-f ahow 1 ☐ Yes 2 ☑ No Director Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code ö Itama 23a 1002 Winfield Drive 21015 **USA** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. TYPYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) oe filed within 7. al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 Underground Electric Company Splicer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fit.
Depertment of Health and Mental Hy
Important: If item 27 is marked oth
any lighry or other traumatic avant
ones. Be William Stanley Smith, Sr. Helen Vera Archer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joy Smith / Wife 1002 Winfield Drive, Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 9-5-06 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Myocardial Infarction Immediate Cause (Final Acute MINUTE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical MHL / L(hald # 030073)Division of Vital Records, P.O. Box 68 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes ecudent 1 Yes 2 No 3 Probably 4 Donknown Completed 24a. Was an autopsy performe 24b. Were aulopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) 1 ☐ Yes 2 ☐ No 2 Outpatient 3 DOA After this To the Mospitel or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie D35012

25+1

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LYNCH

SFP 0 6 2006

Levin

32. Registrar's Signature

2

ORIGINAL

North Ave. Bel Air, Md 21014

DHMH 17 Rev 1/2001

Registrar

			For State of Maryla 1 - State Registrar	nd / Depa <i>Cei</i>	artment of Hea <i>rtificate of De</i>	llth and Me <i>ath</i>	ntal Hygie	2006	28092
			1. Decedent's Name (First, Middle, Last)			2	. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Robert Lee Seidlich				Sept.	3, 2006	1:00P M
	Examin		4a. Facility Name (If not institution, give street and number) 2605 Thornbrook Road		4b. City, Town, or Loc			4c. County of Death	1
				. last birthday)	l	tt City Under 24 Hrs. 8	. Date of Birth	Howard	
	Funeral Director		212-07-5119 ¹ ⅓ ^{M 2□ F} 88	Yrs.		ours Min.	April 1,	1918	place (State or Foreign MD
	land		Usual Residence of Decedent 10a. State 10b. County 10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Mary Find	tor	MD Howard	E1	llicott Cit	y			1 ☐ Yes 2 🛣 No
	th the	lrec	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	ntry?
	23a	raic	2605 Thornbrook Road			042		USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dapertment of Health and Mental Hygiene. important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Wyes 2 No If Yes, Give 1941		Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2 ☒ No Si	nic Origin? (Specif lexican, Puerto Ric pecify:	ly Yes or No- can, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
5	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done durin	ı g most of working	166	. Kind of Business/In	dustry
12	within ane. then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired) Logistician	, ,		ederal Gov	vernment
о 5	Hygie other ant, II	e Co	17. Father's Name (First, Middle, Last)			Mother's Name (/			- CIIIII CII
an	Aental Aental rked o	To Be	William Seidlich		-	Mary Ru	uth Phela	an	
Maryland	short and N		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and I	Number or Rural F	Route Number, Ci	ty or Town, State, Zip	Code)
	and sealth m 27		Mrs. Takako Seidlich (Spouse)	arrest to the second	Thornbrook				
סכ	ages 1 or of H or of		I C Bullat 2 C Chemation 2 C Hemoval nom 2 (416		natory or other place)	Dat		. Location - City or To	
Baltimore,	ertmer prtant prtant injury		4 Donation 5 Other (Specify) Entombment Co		n Mausoleum			rriotsvil	·
Ba	Dape impo any ir		Duan L Hayer Mo	0764 5	Name and Address of IAIGHT FUNE Sykesville,	RAL HOME MD 21784	& CHAPE 4 (410)-	PA (Box 795–1400	195)
	Pnysician /Medical		23a. Part1. Enter the disease, or complications the caused the deathock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	mysp	er the mode of dying, su	uch as cardiac or r	espiratory arrest,	ī	Approximate Interval Between Onset and Death
	Examiner		(200	YWY /	Arry 1) (5P=5	9		2 years
	ם ב	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	queno of):	1 /1:	01	7	. 0	
	end Frans	xam	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a conse	C. (19)	steward	Mulmer	my Do	6-24	hemy.
68760,	ficate be execut! d physicien end s the burial-transit			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		/	<i>7</i> :		E1
_	ifficate g phy: as the	ledicai	0.						
P.O. Box	The law requires that the death certifule has been signed by tha ettending ate has been signed by the ettending bage 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregrent in the past 12 months? 1 □ Live birth 2 □ Fel the pregnant at time of 9 □ Unknown	al death 3	Ectopic pregnancy Other (specify)		_	23d. Date of delive Month	ery Day Year
rds, P	w requires that been signed b should be deta	۵	Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause given in	Part I.	23e. Did tobacc	co use contribute to t	N =
Division of Vital Records,	n: The law re icate has be r, page 2 sh	Completed					24a. Was an autopsy performed	? prior to co	ppsy findings available impletion of cause of 2 No
Ĭ	siciar s certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	☐ ER/Outpatier	Other	Place of Death (6 COtton (6	
0	g Phy er this ieral d	n: To	27. Manner of Death 28a. Date of Injury	28b. Time of	IL 30 DOA		d. Describe how i	6 ☐Other (Special of the first occurred occurre	γ)
jo	andin aath. or: Aft he fun	atlo	Accident investigation	Injury		2 🗆 No			
DIV!	or Attanding Physician: efter death. Director: Atter this certifica I in by the funeral director, p	Certification:	3 ☐ Surcide 6 ☐ Could not be determined 28e. Place of Injury - At I building, etc. (Special Coulding)	nome, farm, str lify)	eet, factory, office	281	f. Location (Street City or Town, St	t and Number or Rura tate)	al Route Number,
	To the Hospital or Attending Physician: The I within 24 hours efter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kr 2 Medical Examiner: On the basis of examinating and manner stated.	nowledge, death	h occurred at the time, divestigation, in my opinio	ate and place, and n, death occurred	d due to the cause at the time, date	e(s) and manner as s and place, and due t	itated. o the cause(s)
	orthin ortha	Med	29b. Signature and title of certifier		29c. License nu	mber	29d.	Date signed (Month,	Dey, Year)
	- > = 0		M		D478	206	50	akohar 5	12016
6	5		30. Name and address of person who completed cause of death (Ite	m 23a) (Type,		11		7	12016 Hom M
1)		23 CTS TOO DOLS	1)8 30	25, ONY5	m1/5,1	D 2///	1-)e~	HUM MI)
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 6 2006 32. Proistrar's Sign	S. G	soule				
			021	- /					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 16a, 18 per fh 9859 9-6-06 vt

State of Maryland / Department of Health and Mental Hygiene 2006 28093 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death SOLOMON Spotowiser **Physician** MILTON 7 AM 2006 /Medical 4a. Facility Name (If not institution, give street and number)

SINGE (TOP) 1 FOL OF ROLL 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore City N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 05/12/1920 Birthplace (State or Foreign Country)
 NIV **Funeral** Days 1 M 2 □ F 220-09-0273 NY Director Usual Residence of Decedent 72 hours after deeth with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or Iteme 23a or 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 💢 No BALTIMORE Funeral Director BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21208 9006 PITTSFIELD ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married WHITE Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ģ 3 Widowed 4 Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Importent: if Item 27 Ie marked other then "natteny or other traumatic event, the Medical Once. Elementary/Secondary (0-12) College (1-4or 5+) OWNWR Owner AMERICAN HEATING CO. NOMOTOS POLITIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) TERKELTAUB Be TERKEHTAUB SOLOMON SAMUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9006 PITTSFIELD ROAD - BALTIMORE, MD 21208 JEANNETTE SOLOMON / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BETH TFILOH CEMETERY | 09/03/2006 WOODLAWN, MD 4 □ Donation 5 □ Other (Specify) of uneral Service Lic-22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one car's, on each line. Approximate Interval Between Onset and Death Acute Myocardial inforction Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Acute Upper Gastrointes tinal bleeding Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed porlipidemia 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No leptic Ulcer difease 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1/2 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

DHMH 17 Rev 1/2001

SFP 0 6 2006

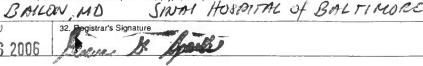
Kear Sactay, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

OSCAR V-



RES-000

September 2, 2006

cian	Ragistrar 1. Decedent's Name (First, Middle, Last)		rtificate of		2. Date of Death		3. Time of Dear	
lical	Willson C. S	wartout				August 1		8:15 AM	
iner	4a. Fecility Name (If not institution, give					h	4c. County of	Death	
	321 Casparus			Elktor			Cec	i1	
1	5. Social Security Number 6. Se 098-22-2942 15 2 Usual Residence of Decedent	x 7. Age (In)	yrs. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		^{Year)} 19130	n. Birthplace (State or For Country) New York	
	10a. State 10b. County	10c	. City, Town or L	ocation				10d. Inside City Lin	
to	MD Cecil		E1kt	on				1 ☐ Yes 2 ☐	
Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	at Country?	
<u>a</u>	321 Casparus Way				21921		USA		
ner	11. Marital Status	12. Was Decedent Ever i Armed Forces?	in U.S. 13.	Was Decedent of H	Hispanic Origin? (S	pecify Yes or No-		American Indian, White, etc.	
五	1 Never Married 2X Married	1X Yes 2 No		1 Yes 2 No		,	Specify:	white	
d by	3 Widowed 4 Divorced		9-53						
Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo.	rking	6b. Kind of Busin	ness/Industry	
duic	Elementary/Secondary (0-12)	College (1-4or 5+)	me.	engi	•		rical		
S	17. Father's Name (First, Middle, Last)			011621	18. Mother's Name (First, Middle, Maiden Surname)				
To Be	Chester Swartout			Agnes Kok					
F	19a. Informant's Name/Relationship (T)	vpe, Print)	19b. Maili	na Address (Street	and Number or Ri	ural Route Number,	City or Town Str	ate Zin Code)	
	Dawn Swartout/spo			1 Casparı			21921	, 2,5 0000)	
	20a. Method of Disposition		b. Place of Dispo	osition (Name of			Oc. Location - Cit	ty or Town, State	
	1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 ☑ Donation 5 ☐ Other (Specify)		сетпетегу, сте	matory or other pla	ce)				
	21. Signature of Euneral Service Licens	99 1/	2	2. Name and Addre	ess of Facility	1 (
	Monard S.	100 ct		tate Anat altimore,		d 655 W.	Baltimor	e Street	
al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	eading to immediate Enter Underfying (Disease or injury lated events g in death) Last Due to (or as a consequence of): Due to (or as a consequence of):							
lical									
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3		23d. Date of delivery Month Day				
	Part II. Other significant conditions con	ntributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribe	ite to the cause of death?	
d by						1 ☐ Yes	2 12 No 3 [☐ Probably 4 ☐Unkno	
lete						24a. Was an	24b Wes	e autopsy findings availa	
Completed						autopsy perform 1 Yes 2	ed? prio	r to completion of eause	
Be	25. Was case referred to medical examiner?	lospital:		oth Oth	00	th (Check only one			
<u>۲</u>	1 Yes 2 No	28a. Date of Injury	2 ER/Outpatier 28b. Time o	IL SEL DON	4 Nursing H	ome 5 Residen		Specify)	
lö l	1 Natural 5 Pending	(Month, Day Year	r) Injury	Wor	yan k? Yes 2∐No	28d. Describe hov	v injury occurred		
Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	at home, farm, str ecify)		163 2 0,100	28f. Location (Stre City or Town,		or Rural Route Number,	
	29a. Certifier 1 Certifying Phy. (Check only one)	sician: To the best of my	knowledge, death ination and/or in	h occurred at the tirvestigation, in my o	me, date and place pinion, death occu	, and due to the cau rred at the time, dat	use(s) and manne e and place, and	er as stated. due to the cause(s)	
dica	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated. 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month,								
Medical	29b. Signature and title of certifier	1/ 1				-	11 2		
Medica	29b. Signature and title of certifler	faul		1/2	51.52	X	12200	5	
Medica	29b. Signature and title of cartifler 30. Name and address of person who co	moleted cause of death //	Item 23a) (Tuno	D3	5653	8	12200	5	

DHMH 17 Rev 1/2001

State Registrar

SEP 0 6 2006

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of Marylar	nd / Departme <i>Certifica</i>	ent of He	alth and I			28095
			Registrar Decedent's Name (First, Middle, Last,)	Cerunce	ale of Di	eaur	2. Date of Dea		3. Time of Death
	Physici /Medi		MARGARET	TAYLOR				Month	4 86	5-13 DM
	Examir		4a. Facility Name (If not institution, give	street and number)	4b. C	ity, Town, or Lo	you fa	rK	4c. County of Dea	NA
	Funeral Director		5. Social Security Number 6. Sec. 2/2-16-9235	7. Age (In yrs.	Ast birthday) If Un Month		Under 24 Hrs. Hours Min.	8. Date of Birt Month, Day August	rear)	thplace (State or Foreign
	show ed al	or.	Usual Residence of Decedent 10a. State 10b. County		ty, Town or Location	0 /	1.41			10d. Inside City Limits 1 ☐ es 2 ☐ No
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23s or 28e-f show other traumatic avent, the Medical Exempetermant be notified at	Director	10e. Street and Number			Zip Code	1225	-	10g. Citizen of What C	
	ma 23	Funerai	11. Marital Status	12. Was Decedent Ever in U	I.S. 13. Was De	cedent of Hisp	anic Origin? (S	pecify Yes or No-	14. Race - Ame	
920	ours after ai', or ite Exertine	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 1040 If Yes, Give Year or Dates:		- 11	Mexican, Puert	Hican, etc.)	Specify: B	lac K
215-0036	"natur	leted	15. Decedent's Edu (Specify only highest grad		16a. Decedent's U	work done duri	on ing most of wor	king	16b. Kind of Business	/Industry
2	filed within Hygiene. That then "that the that the the that the theta the that the theta the the that the theta the	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	FACTOR	y We	orker		FACTOR	4
Maryland	iould be filed Mental Hygir harked other	To Be (17. Father's Name (First, Middle, Last)	nes		18	8. Mother's Nam		Maiden Sugrame)	/
Mary	od 2 shoulth and h		19a. Informant's ame/Relationship (Ty	pe, Print) Son	- 10	ess (Street and	4 4	ral Route Numbe	r, City or Town, State, .	to MG 21229
nore,	0 0 = =		20a. Method of Disposition 1 Burial 2 Cremation 3 F	20b. I	Place of Disposition (I	Name of or other place)	1	Date 12-06	20c. Location - City or BAH: More	Town, State
Baltimore,	permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	1/1/2/Men	22 Name	and Address	of Facility Brown		uneras H	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the deal	th. Do not enter the m		such as cardiac	or respiratory an	rest,	Approximate Interval Between
學	Physician /Medical Examiner supply strians it the prival-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect Due to	ES M quence of): TENSION	ELLI) <i>E</i> N7		Onset and Death
. Box 6	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnant 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of conductions	al death 3 Ectopic				23d. Date of de Month	ivery Day Year
	uires that signed by Id be deta	by	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the underlyin	g cause given i	in Part I.		bacco use contribute to	
	ician: The law requires that the certilicate has been signed by th ector, page 2 should be detache	Completed						24a. Was a autop. perfor	med? prior to death?	utopsy findings available completion of cause of
₹		To Be	25. Was case referred to medical examiner?	lospital: 1 Inpatient 2	ER/Outpatient 3	Othon		th Check only or		
n of	ding Phys h. After this funeral di		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?			ence 6 Other (Spe ow injury occurred	city)
ivisio	or Attending after death. Diractor: After in by the fune	ertification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h	M ome, farm, street, fact		s 2 □ No	28f. Location (S City or Tow	treet and Number or Ri n. State)	ural Route Number,
	To the Hospitel or Attenwithin 24 hours after deati To the Funeral Diractor: completely filled in by the	O	29a. Certifier 1 Certifying Phys	sician: To the best of my kno	owledge, death occurr	ed at the time,	date and place,	and due to the o	ausa/s) and manner as	stated.
	the Ho The Fu	ledical	one) 2 Medical Examil	ner: On the basis of examina and manner stated.	ition and/or investigati	on, in my opini	ion, death occur	red at the time, o	late and place, and due	to the cause(s)
	with To	Σ	29b. Signature and title of certifier	petting		29c. License ni			29d. Date signed (Mont	1
	ران		30. Name and address of person who co	mpleted cause if death (Item	n 23a) (Type, Print)	D23	100	2	2122	0
Name of Street	4		ASHOKK CHA	TTENDEC,	3927 A	NWA	POLIS!	(mon)	2122	7.
	Sta Registr		31. Date filed (Month, Pay, Year) 6 20	06 32. Registrar's Signa	iture .	0				

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State of Maryland / Department of Health and Mental Hygiene 2006

28096

			1 - For State Ragistrar	olulo ol muryami	Cei	rtificate of	Death		Reg. No.	20000
	Dhuaiai		1. Decedent's Name (First, Middle, Last		,			2. Date of Dea		3. Time of Death
	Physici /Medio		Hazel	E Tem,	ple			9	4 06	3:35 AM
1	Examin	er	4a. Facility Name (If not institution, give Renaissance Ga			4b. City, Town, o	r Location of Death		4c. County of Death	
	Europal		5. Social Security Number 6. Se		ast birthday)		VIIIE If Under 24 Hrs.	8. Date of Birt	Baltimo	
	Funeral Director			M 2XIF 97	Yrs.	Months Days	Hours Min.	OCT 6	, 1908 Rho	place (State or Foreign intry) de Island
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mar and	ctor	MD Baltim	ore Cat	tonsv	ille				1 ☐ Yes 2 🙀 No
	n with the	al Director	10e. Street and Number 715 Maiden Cho	ice Lane		10f. Zip Code 21228			10g. Citizen of What Cou USA	intry?
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. V	Was Decedent of H	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri Black, White	
Maryland 21215-0036	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It is marked other then "neturel", or Itema 23e or 28e-f show traumatic event, Ite Medicel Examinating the notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐XNo		, , , , , , , ,	Specify: Whi	
5-0	natu dicel	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Deced (Give	dent's Usual Occup	nation during most of work d)	ing	16b. Kind of Business/Ir	ndustry
121	within ane. then	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)		isticia:	-	Į.	Business Of	fico
d 2	filed Hygid Sther	e Co	17. Father's Name (First, Middle, Last)		Stat.	ISCICIA			Maiden Surname)	rice
lan	should be and Mental a marked c	To B	Walter J. Smit	h			Frances	в Е. Ме	erchant	
ary	2 should be and Mental is marked aumetic av	-	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailin	ng Address (Street	and Number or Rur	al Route Numbe	r, City or Town, State, Zi	o Code) 63367
	and 2 saith a n 27 is		Grant MacLaren	, Cousin/POA	5 E	dgewate:			Saint Lou	is, MO
ore	ges 1 and t of Healt if Itam 2 or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ I		emetery, cren	sition (Name of matory or other place	ce)	Date	20c. Location - City or T	
Baltimore,	t. Pag rtment rtent:		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)						Baltimore	•
Bal	permit. Pages to Department of Himportant: If Italiany injury or ot once.		21. Signature of Funeral Service Licens	S. Todd Dri	ing C	remation	n Societ	y of N	Maryland,	Inc. 21228
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the death						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	and the same of th	100	Demen	tia			Onset and Death
À	/Medical		resulting in death)	Due to (or as a consequ	ience of):	· Crrick	4100			
	Examiner		Sequentially list conditions,	o						
	ed sit	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (ur as a eonsequ	ianea ot):					
^	axecul and al-trar	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	ience of):					
68760,	certificate be executed Iding physicien and Ise as the burial-transit			d						
	E 50 g	Medical	IF FEMALE:							
P.O. Box	death e atter	Physician/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)	/		23d. Date of deliv Month	ery Day Year
	requires that the een signed by th hould be detache	by Pr	Part II. Other significant conditions co	ntributing to death but not resu	Iting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to t	he cause of death?
rds	w requires been sign should be	ed b	Anorexia					1 🗆 Y	es 2 □ No 3 □ Pro	bably 4 Unknown
Division of Vital Records,	aw 2 st	Completed						24a. Was a		opsy findings available ompletion of cause of
= E		Con						perfor		2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		0#	26. Place of Deat			
o	Physic ral director	. To	1 Yes 2 No	1 Inpatient 2 E	ER/Outpatien 28b. Time of	t 3 DOA	4 Nursing Ho		ence 6 Other (Speci	fy)
o	Attending Phr r death. actor: After thi by the funeral	ıtlon	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No	200. 2000.100 11	on injury securiou	
Visi	l or Attan after deat Diractor: I in by the	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hos building, etc. (Specify,	me, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Number or Run	al Route Number,
Ö	afte din din	Cert								
	5 6 0		29a. Certifier 1 Certifying Phy	sician: To the best of my know	wledge, death	occurred at the tin	ne, date and place, pinion, death occur	and due to the o	ause(s) and manner as s late and place, and due t	stated.
	a Hospital 24 hours a Euneral I	dlcal	(Check only 2 Medical Exami	and manner stated.		· · · · · · · · · · · · · · · · · · ·				o mo causa(s)
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	one)	and manner stated.						
	To the Hospita within 24 hours To the Funera completely fille	Medical	one)	and manner stated.						
1	To the Hospite within 24 hours To the Funera completely fille	Medical	one)	and manner stated.						
1	To the Hospite within 24 hours within 24 hours to the Funera completely filled	Medical	one)	and manner stated.						

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Amend I tem 8 per the 884 02/28/07/the and Mental Hygiene 2006 ROSE TURNER 28097 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 31 2006 **Physician** august Rose Lee 12:15 An Turner /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Name (If not institution, give street end number) Examiner Future Care Charles Village Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Funeral 1 □ M 2 🖔 F Yrs. VA 91 UNIO3/03/1915 Director 217-18-5412 Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any hjury or other traumatic event, the Medical Evariner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 17☑ Yes 2☐ No Director N/A Baltimore 10g. Citizen of What Country? 10f Zip Code 10e. Street end Number 11 W. 20th St 21213 USA Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ☐ Yes 2X No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify Year or Dates: 3 Widowed 4 □ Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Services In Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) UNK 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3308 Lyndale Ave Baltimore, MD 21213 Alva Turner/niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XX cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/31/04 Baltimore, MD Metro Crematory, Inc 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility
Cremation Society of Maryland, Inc. 1. SK 299 Frederick Rd Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List poly one cause on each line. Approximate Interval Between Onset and Death **Physician** periperal Vascular disEASE Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of): Examiner DIABETES mellitus ettending physician and for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Due to (or as a consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably X ☐ Unknown CHRUNIC UF anemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 TYUS 2K No 1 ☐ Yes 2 ☐ No edical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 Pending investigation Naturel 1 🗌 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 🔀 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 35102 OM MO august 31, 2066 Willelle

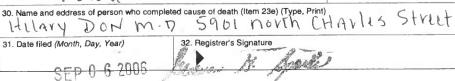
or Attending Physician: The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760, within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funeral di To the Vithin 2

Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year) State Registrar



ORIGINAL

Baltimore

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			1 - For State Registrar	State of Mary	Cer	tificate of	Death		g. No.	28098
	Physici	an	1. Decedent's Name (First, Middle, Last					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	James Dixon Trenchard,			4b. City, Town,	or Location of Death	September	2, 2006 4c. County of Dea	9:55 A. M
18 . Al	E Admin	ger d	5904 Burgess Avenue			Baltimore			N/A	
8	Funeral Director		5. Social Security Number 6. Se 218–10–9527 10 Usual Residence of Decedent	X 7. Age (In 8	yrs. last birthday) } Yrs.	If Under 1 Year Months Days		8. Date of Birth Month Day August 13	, 1918 Mar	thplace (State or Foreign ountry) y l an d
	yland sow		10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	Ba-fet	ctor	Maryland N/A		Baltimore					1 Yes 2 □ No
	th with th	Funeral Director	10e. Street and Number 5904 Burgess Avenu	ıe		10f. Zip Code 21214		10	Og. Citizen of What Co	ountry?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show simply injury or other traumatic event, it is Madical Examinar must be notified at ance.	b	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 XYes 2 □ No I If Yes, Give Year or Dates:	WII I I I W	Vas Decedent of t i Yes, specify Cub ☐ Yes 2 X No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	te, etc.
15-0	"natu	etec	15. Decedent's Edu (Specify only highest grad	ication le co <i>mpleted)</i>	(Give	lent's Usual Occu kind of work done OO NOT use retire	during most of wor	rking	6b. Kind of Business	/Industry
212	y withir piene. r then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ighter	0)		Fire Depar	rtment
nd	2 should be filed with and Mental Hygiene. Ie marked other the aumatic event, Ire	BeC	17. Father's Name (First, Middle, Last)					ne (First, Middle, M		
Maryland	should to nd Ment marked	2	G.P. Nesbitt Trend		10) 11		Nannie I			
Na Na	and 2 st ealth and n 27 le r		19a. Informant's Name/Relationship (T) Virginia Kauffman,			Roland A		altimore	City or Town, State, . Marvland	21210
Je,	of Health of Health litem 27 r other tr		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ F	26	Ob. Place of Dispos cemetery, cren				0c. Location - City or	
Baltimore,	permit. Pages Department of it Important: If its eny injury or or ance.		4 ☐ Donation 5 ☐ Other (Specify)	Namovai nom State	lew Cathe	dral	9/6	6/06	Baltimore	Maryland
Bal	permit. Departr Importa eny inj		21. Signature of Funeral Service Licens Chustye L.	Hitten	122 16 53	Name and Address Conard J. F 805 Hartor	ess of Facility Ruck Inc I Road Bal	timore Mary	land 21214	
			23a. Part1. Enter the disease, or compi shock, or heart failure. List only o	lications that caused the ne cause on each line.			,	or respiratory arre	st,	Approximate Interval Between Onset and Death
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7	ed sit	niner	Sequentially list conditions, it any, isading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or se s eo	reequaries of):					
v Ć	icate be executed physicien and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cor	nsequence of):					
68760,	ate be hysicie he bur	fedicai		d						
9 X	certific iding pl		IF FEMALE:	23c. If yes, outcome of pr	egnancy				22d Date of do	livan
.O. Box	The law requires that the death certificate be executed lie has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc Other (specify) _	у		23d. Date of de Month	Day Year
Records, P.	quires that n signed b	by	Part II. Other significant conditions co	ntributing to death but no	t resulting in the ur	nderlying cause gr	ven in Part I.		acco use contribute to s 2 □ No 3 【*P	o the cause of death?
ecol	e law requir has been si je 2 should	Completed						24a. Was an		utopsy findings available completion of cause of
E B	: The cate h	Соп						perform	ed? death?	2 □ No
Vital	Physician: Th this certificate ral director, peg	9 Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	a∏50/0 · · ·	Ottoo. Ott		th Check only one		
o	ding h. After fune	tion: To	1 Yes 2 No 27. Manner of Death 1 Manurat 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time of Injury	28c. Inju	4 □ Nursing H	28d. Describe how	nce 6 Other (Spe w injury occurred	city)
Division	P H S	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, streedecify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Directompletely filled in by	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my ner: On the basis of exa and manner stated.	knowledge, death mination and/or inv	occurred at the ti restigation, in my	me, date and place opinion, death occu	, and due to the car rred at the time, da	use(s) and manner as te and place, and due	s stated. e to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier			29c. Licens		29	d. Date signed (Mont	h, Dey, Year)
	. 0		Charles Pad	gett up		Dis	546	S	opt 5 20	006
	20		30. Name and address of person who	leted cause of death	(Item 23a) (Type, I	Raven	Blud.	Baltin	hove. N	006 UD 21239
7	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's S		elle)		•		-

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			For State Registrar	State of Ma	arytanu / D	Certificate of	Death		Reg. No.	28099
12	Physici	an	1. Decedent's Name (First, Middle, La	•				2. Date of Dea Month	Day Year	3. Time of Death
	/Medio	cal	ODETTE 4a. Facility Name (If not institution, gire	S.	TOOM		or Location of De	AUGUST	31, 2006 4c. County of Dea	
	Examir	ier	111 EDGEWOOD ROA			TOW		eau i	BALTIMO	
100	Funeral Director			Sex 1 □ M 2 ☆ F	e (In yrs. last birti 85	hday) If Under 1 Year Months Days		Hrs. 8. Date of Birth (Month, Day 05/01/	9. Bir (, Year) Fra	thplace (State or Foreign puntry) INCE
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Maryli f sho	tor	MD Baltimo	re	Tows					1 ☐ Yes 2 No
	or 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	ath will	raiD	111 Edgewood Roa	T		21286			U.S.A.	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. I hatural, or Itame 23a or 28a-f show event, the Medical Exemities in the notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 1 If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cub		? (Specify Yes or No- uerto Rican, etc.)		
5-0	72 hc	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Decedent's Usual Occu (Give kind of work done	during most of	working	16b. Kind of Business	/Industry
121	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5		`life. DO NOT use retire omemaker	ed)		Own Hon	ne
d 2	Hygin other	Be Co	17. Father's Name (First, Middle, Las		110	Jillellaker	18. Mother's I	Name (First, Middle,		
lar	should be nd Mental marked o	To B	Alfred Adams	5			Ceci	le Bi	rumberg	
Maryland	l 2 sho		19a. Informant's Name/Relationship			Mailing Address (Stree				Zip Code)
	1 and Health		Diane C. Chotiku	l / Daughte		1 Edgewood Disposition (Name of commatory or other pla		Date Date	20c. Location - City or	Town, State
MO	Pages nent of ant: If its		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Cont	Removal from State		y, crematory or other pla Crematory,		/05/2006	Catonsvill	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: if Item 27 Is marke any injury or other traumatic anges.		21. Signature of Funeral Service Lice	nsee					N FUNERAL	HOME, P.A.
8	90E = 9		<u>'</u>			8521 LOCH	RAVEN E	BLVD. TOW	SON, MD 2	1286
	Dhuaisian		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each li	the death. Do n	ILIA EMA	11130			Approximate Interval Between Onset and Death
37	Physician /Medical		disease or condition resulting in death)	aDue to (or as	a consequence, o	(f):				The state of the s
42	Examiner		Sequentially list conditions.	b. Par.	MINTE	a AS190	ms			2 monin
	led (a) Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of	1): Pors	kins	ono de	sease	2 month 4 years
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	ertifica ling pt	Med	IF FEMALE:	000 16	-1					
.O. Box	that the death cer ed by the attendin detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	су		23d. Date of de Month	livery Day Year
<u>α</u>	es that the igned by th be detache	by Pi	Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlying cause gi	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ord	w requires been sign should be							_ 1□Y	es 2.DNNo 3□P	robably 4 Unknown
Division of Vital Records,	The law ete has b page 2 si	Completed						24a. Was autop perfor 1 Yes	sy prior to	utopsy lindings available completion of cause of
Vita	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		- 0:	hor	Death (Check only or		
ō	Physer this eral di	n: To	1 ☐ Yes 2 No 27. Manner ol Death	28a. Date of Inju	ry 28b. T	ime of 28c. Inju	4 🗆 Nulsiii	/ 4	ence 6 Other (Spe	ecify)
ion	Attending in death.	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	/ .	y Year) In		ork?]Yes 2∐No	NA		
ivis	r the c	Certification:	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined			m, street, factory, office		28l. Location (S City or Tow	itreet and Number or R n, State)	ural Route Number,
	Hospital 24 hours at Funeral Dietely filled it		29a. Certifier Certifying P	hysician: To the best	of my knowledge,	, death occurred at the t	ime, date and pl	ace, and due to the o	ause(s) and manner a	s stated.
	he Ho in 24 h he Fu pletely	edical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	examination and	Vor investigation, in my	opinion, death o	ccurred at the time, o	date and place, and du	e to the cause(s)
)	To the within 2 To the Complet	Σ	29b. Signature and title of certifier P. C. Mark	the M			se number 7	182	29d. Date signed (Mon.	th, Day, Year)
_ (lot 1		30. Name and address of person who	completed cause of d	eath (Item 23a) (305)	Type, Print) P. C	NAF	IS ala	86.	
*	Sta Registi		31. Date filed (Month, Day, Year)	32. Region	ar's Signature	TOWSO	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 006 28100 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2006 15an /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Perring Paulcuag

7. Age (In yrs. last birthday) Kalhman Utnesis Baltomore If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 ☐ M 2 🕏 F Director 143-56-9854 10/12/1931 CHINA Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show rthan "natural", or Items 23a or 28a-f shov the Medical Examiner Total be notified at 1 ☐ Yes 2 🙀 No MD BALTIMORE **Funeral Director** PARKVILLE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 1904 WILDWOOD AVENUE 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: ASIAN Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. OWN HOME 12TH GRADE HOMEMAKER permit. Pages 1 and 2 should be file Department of Heelth and Menial Hy Important: If Item 27 is marked other any Injury or other traumatic event, SDGS. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be CHOUNG WONG TAI LAI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HAK TSANG/HUSBAND 1904 WILDWOOD AVENUE BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State GLEN HAVEN MEM. PARK 9/8/2006 GLEN BURNIE, MD * 4 ☐Donatigh 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fied. Approximate Interval Between Onset and Death Immediate Cause (Final Rectal Cancer Pnysician disease or condition resulting in death) 4 4 caus /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, each of terminal dis-cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and Properties of the parties of the parties of the purial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 9 Unknown signed b Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown hemi paresis 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Cancu autopsy performed? 28 No this certificate 1 Yes the Hospital or Attending Physician: 26. Pface of Death (Check only one) Be 25. Was case referred to medical examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🗙 No 28c. Injury at Work? 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 Tes 2 No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Which Klein 1231295 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Coach

Kloisz

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32. egistrar's Signature

			1 - For State Registrar	State of M	arylan	a / Depa	artm <i>rtific</i>	ent of He ate of D	eaith and i Death	nentai Hy	gien Reg. N	^e 2001	6 28101
	Physici	an.	1. Decedent's Name (First, Middle	, Last)						2. Date of De Month		ay Year	
	/Medic			Masahir		oyama	T			August	_30	, 2006	2:45 A M
	Examin	er	4a. Fecility Name (If not institution,)				Location of Death		4	c. County of Dea	
	Funeral		Holy Cross Hos 5. Social Security Number	·	ge (In yrs.	last birthday)	_ If U	nder 1 Year	Spring If Under 24 Hrs.	8. Date of Bir	th .	Montgo 9. Bi	official of State or Foreign country)
	Director		220-70-5073	1 X M 2□ F	66	Yrs.	Mon	ths Days	Hours Min.	8. Date of Bir (Month, Da Oct. 7	y, Year	939 J	apan
	yland 10W		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	be filed within 72 hours after death with the Maryland itel Hygiene. Inclural, or Items 23e or 28e-f ahow event, it a Medical Examinar must be notified at	Director	Maryland Montge	omery			Roc	kville					1 ☐ Yes 2 X No
	or 28	Dire	10e. Street and Number				10f	. Zip Code				itizen of What C	
	s 23e	ra	1733 Sunrise Dr	rive 12. Was Decedent	- Everia II	6 12	Wee D	208		naid. Van as Na		ited Sta	
(0	r Item	Completed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Marrie	Armed Forces	?	1			spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)	•	Black, Whi	
21215-0036	iral', o	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1	s 2 💢 No	Specify:			Specify: A	sian
5-	netu	lete	15. Decedent' (Specify only highes	s Education t grade completed)		(Give	kind o	Usual Occupati f work done du	tion uring most of work	king	16b.	Kind of Business	:/Industry
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b	il Hygid other	Be C	17. Father's Name (First, Middle, L	.ast)			Oric		18. Mother's Nam	ne (First, Middle,			10
/lar		ToE	Kamekichi Uenoy	yama					Tori Go	mi			
Maryland	2 sho		19a. Informant's Name/Relationsh			19b. Mailir	ng Add	ress (Street a	nd Number or Rui	ral Route Numbe	er, City	or Town, State,	Zip Code)
	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		Noriko Uenoyama,	/Wife	20b P	1733			rive, Ro	ckville Date		ary land	
п	Pages nent of I int: If Its iry or o		1 ☐ Burial 2 【X Cremation 4 ☐ Donation 5 ☐ Other (Sp		, c	emetery, crei	matory	or other place	Sept.	1.		,	
Baltimore,	그 돈 큰 글		21. Signature of Funeral Service L		l ^v bn			matorium e and Address)6	Bet	hesda,	Maryland
ä	Departing Department of the partment of the pa		1 Kut	~	MOO	$198 {}_{30}^{R}$	obe OO W	rt A. Jest Mor	rumphrey itoomerv	runera Ave Roc	l Ho kvi	ome/Kock 11e_MD	kville, Inc. 20850-2805
			23a. Part 1. Enter the disease, or o shock, or heart failure. List of	complications that cause only one cause on each I	d the deat ine.	n. Do not ent	er the	mode of dying	, such as cardiac	or respiratory a	rest,	,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)				tri	c Canc	er				years
	/Medical Examiner			Due to (or as		,	1 - 1						1
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68760,	g phys	edicai		d									
Вох	eath certif attending for use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			TEctor.	ic pregnancy				23d. Date of de	elivery
	ne death the atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant a				r (specify)				Month	Day Year
P.0	that the died by the deteched		Part II. Other significant condition	ns contributing to death !	out not res	ulting in the u	nderlyi	ng cause giver	n in Part I.	23e. Did t	obacco	use contribute t	to the cause of death?
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eco	e lawre has bee je 2 sho	Completed								24a. Was		24b. Were a	utopsy findings available completion of cause of
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	g Physie this	٥	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju		ER/Outpatier 28b. Time of		28c. Injury	at at	ome 5 Residence 1		6 Other (Spe	ecify)
ion	uttending death. ctor: Afte / the fune	atlor	1 Natural 5 Pending 2 Accident investig		y Year)	Injury	М	Work's	es 2 □No			,	
Division	or Atte ter de: Irecto n by th	Certification:	3 ☐ Suicide 6 ☐ Could no determine	ot be ned 28e. Place of In building, e	jury - At ho	ome, farm, str	eet, fac	ctory, office		28f. Location (City or Tox			Rural Route Number,
Ω	pital o		29a. Certifier 1 Certifying	Physician Tathahad	at m len a							 	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, i	Medical	(Check only 2 Medical E	Physician: To the best examiner: On the basis of and manner st	of examina	tion and/or in	vestiga	ition, in my opi	nion, death occur	red at the time,	date ar	s) and manner a nd place, and du	s stated. e to the cause(s)
	To th withir To th comp	ž	29b. Signature and title of certifier	0				29c. License				ate signed (Mon	
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	1 +		AHMED No	mo completed cause of a		1 23a) (Type,		9 G	wither	rs bur	9	mo	20883,
	Sta	te	31. Date filed (Month, Day, Year)	32. Pregist	rar's Signa	turo	4-						,
	Registr	ar	SEP 0 6	2006	iner.	M. A	284	w					

State of Maryland / Department of Health and Mental Hygiene For State Registra 28102 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 4:50 р м Margaret C. Weidenhammer 2006 September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Villa Nursing Home Catonsville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | Mgnth, Day, Year | 09/27/1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 212-09-3550 1 ☐ M 2 🕱 F 89 Director Mar yland Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits other then "natural", or items 23a or 28a-f ehow vent, the Medical Examinar must be notified at Maryland n/a Director Baltimore 1X Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? United States 10f. Zip Code 340 S. Bentalou Street 21223 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: ģ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homemaker 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel J. Toulan Mary Ann Doherty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If Health a item 27 i Deborah A. Stoppard/Daughter 58 Pheasant Ridge Road, Hanover, PA 17331 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H
Important: if its
eny injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Loudon Park Cemetery 09/07/06 4 ☐ Donation 5 ☐ Other (Specify) 2 Six ature of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Pag 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 9 ☐ Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been si, , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 10 of Vital 1☐ Yes 2 1 Tes or Attending Physician: ours after death.

neral Diractor: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one 1 ☐ Yes 2 ☐ M6 Hospital Other: Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Feath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitai within 24 hours a

To the Funeral C

completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signature and title of License number 29d. Date signed (Month, Day, Year) 30. Name and address 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 6 2006 Registrar

06-06341 Please Type or Print in Black Indelible Ink William Whiteley State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day August 24, 2006 1409 hrs Medical Examine William Whiteley 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) **Funeral** Foreign UNK Months Days Hours Director NOV 13. 1957 Country) New York 1X M 2 F 48 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d Inside City Limits 3my 1 Yes 2 X No or 28a-f show Prince Georges Bowie MD notified at once death with the Maryland Director 10g Citizen of What Country 10e. Street and Number 10f Zip Code 20715 USA 8500 Racetrack Road or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black 1 X Never Married 2 Married Armed Forces' White, etc. 2 X No Yes after If Yes, Give Year Widowed Divorced 1 Yes 2 No specify Specify White ş 16a. Decedent's Usual Occupation (Give kind of work done Pages I and 2 should be filed within 72 hours nent of Health and Mental Hygiene ant: If item 27 is marked other than "natur or other traumatic event, the Medical Exami 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry fed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Complet Baltimore, MD 21215-0036 Horse Trainer Equine Industry 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Mary Louise Anderson Charles Douglas Whiteley, Jr. 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas C. Whiteley/Brother 919 Littleton Drive Concord, NC 28025 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition permit Pages I a
Department of He
Important: If ite
injury or other ti crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 9/2/06 Baltimore, MD Metro Crematory, Inc. Donation 5 Other Specify 22. Name and Address of Facility Cremation Society of MD, Signature of Funeral Service Licenses lune 1 A. Gregorchik 299 Frederick Road Baltimore, MD 21228 Edward 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate iner Due to (or as a consequence of): (Disease or injury that initiated events resulting in death) Last Exami Due to (or as a consequence of): requires that the death certificate be executed and Physician/Medica XUNPENDED AMENDED attending physician or use as the burial item#23a,27,perME,g859,9/18/06 TI Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy 1 Live birth Month Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed death? Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medica 26.Place of Death (Check only one To the Hospital or Attending Physician: Be examiner? Other₄ DOA this Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 🗸 Yes 2 No After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work' 28d. Describe how injury occurred Certification: XNatural Yes 2 5 Pending Funeral Director: tely filled in by the Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical To the 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) O.C.M.E August 26, 2006 30 Name and address of person who completed cause of death (Item 23a)

OCMF 2006

State

Pamela Southall, MD

31 Date filed (Month, Day Year)

Assistant Medical Examiner

32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

_			For State Registrar	State of I	Maryland	/ Depa	rtment of H	ealth and I Death	Re	eg. No.		28104
	Physici	an	Decedent's Name (First, Middle, I	Last)					2. Date of Deat Month	Day Y	'ear	3. Time of Death
	/Medic	cal	Irma Wasmus 4a. Facility Name (If not institution, o	rive street and numb	ar)		4b. City, Town, or	Location of Deat		er 2, 20		9:45 P [™]
	Examir	ier	Paradise Assist		·		Catons				timor	:e
	Funeral Director		5. Social Security Number 6 214-01-6011	. Sex 7. 1 ☐ M 2 🔀 F	Age (In yrs. las	<i>t birthday)</i> Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec . 21,	Year) 1909 M	Birthplac Country [ary]	ce (State or Foreign y) and
	pur .		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Lo	cation				10d	t. Inside City Limits
	daryis f sho	ō	Maryland Baltimo	ar o			sville					1 ☐ Yes 21 No
	r 28e-	Director	10e. Street and Number	716		Cator	10f. Zip Code		1	0g. Citizen of Wh	at Country	/?
	th with	a D	15 Cedarwood Roa	ad			212	28		USA		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. item 27 le marked other then "natural", or Items 23a or 28e-f show other treumetic event, Ira Madical Examinational Learnellied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	as? XNo	'	Vas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 🛣 No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Black, Specify:	American White, etc	c.
2-0	72 ho natur lical l	eted	15. Decedent's			16a. Deced	lent's Usual Occupa	ation during most of wo		16b. Kind of Busi	ness/Indu	stry
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Maryland	should be fand Mental He marked of	-	19a. Informant's Name/Relationship	о (Туре, Print)		19b. Mailir	g Address (Street	and Number or Ru	ural Route Number,	City or Town, St	ate, Zip C	iode)
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Baltimore,	of He of He If item or oth		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3	☐Removal from Sta	IIA I		sition (Name of natory or other place			20c. Location - Ci	•	
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Bal	permit. Pages 1 and Department of Heall Importent: If item 2 eny injury or other 00059.		21. Signature of Funeral Service Lie	91600	5 0	22	Funeral 1	Home of	erling As Catonsvil	le, Inc	iwab	WILZNE
			23a. Part1. Enter the disease, or or	omplications that cat	sed the death.	Do not ent			venue; Ca c or respiratory arre		A	ID 21228 Approximate
18	Pny sicia n		shock, or heart failure. Limor Immediate Cause (Final disease or condition			us T	Fractur	10			C	nterval Between Onset and Death
0, 0	/Medical Examiner bhysician and sthe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate causs. Entire Indentity Cause (Disease or injury that initiated events resulting in death) Last	b	as a consequer as a consequer as a consequer	nce of):						
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σ.	that the de ed by the detached		Part II. Other significant condition	s contributing to deat	h-but not resulti	na in the u	ndertving cause give	en in Part I.	23e. Did tot	pacco use contrib	ute to the	cause of death?
ds,	signed k	d by	myocandial	infarct			naony mg oaddo gm				Probab	
Records,	0 5 0	Completed							24a. Was a autops perform	y prii ned? de:	or to comp ath?	y findings available bletion of cause of
Vital	Physicien: The this certificate ral director, pag	BeC	25. Was case referred to medical examiner?						ath (Check only on	e)		A
of V	di S	2	Yes 2□No	Hospital: 1 Inp		VOutpatier		4 [] Nuising i	lome 5 Reside			Assisted Living
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Division	Atten r deat ector: by the	Certification:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	t be age Blace of	Injury - At home , etc. (Specify)	e Jarm, str	eet, factory, office		28f. Location (St. City or Town	411 4 -	or Rural F Se As	Sisted Living
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	the hin 24 the 5 the 5 nplete	Medi	unal	and manner			29c. License			9d. Date signed (
	To To CON	4	29b. Signature and title of certifier	1 mm	~. J.		7 18	667				
•	/		no Name and address of person w	ho completed cause	of death (Item 2	Ba) (Type	Print)	<i>DQ</i> /		eptember	015	2006
	70		PhilipMilitello, M	D 6 Trim	ble H:	II CT.	Lutheru	ille, Mo	myland	2109	3	
	Sta	ate	31. Date filed (Month, Day, Year)	6 2006 N	istrar's Signatur	B AS	forth					

			Please 1 - For State Registrar	State of M			ent of F	Health and M	Mental Hy		_	5 28105
	Physici /Medio		1. Decedent's Name (First, Middle, La GEORGE A. WARD	st)					2. Date of De		2006	3. Time of Death 9:470 M
	Examir Funeral Director		4a. Facility Name (If not institution, gives 5. Social Security Number 6.5. 216-60-6252	uare Ho	SOITAL go In yrs. last b		ROSC nder 1 Year	or Logation, of Death If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sept.	J.	County of Dea 2011119 9. Bir 253 CO	th Direction Control Control
		or	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo	Te		wn or Location	11		СОРОТ			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ith with the Marylan 23a or 28a-f ehow	Funeral Director	10e. Street and Number 8202 Feather Hill				. Zip Code	128		-	zen of What Co	ountry?
38	hours after death with the Maryland turat, or items 23s or 28s-f show at Examiner must be notified at	by Funera	11. Marital Status 1 Never Married 2/(2)Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes XX	Ever in U.S.		ecedent of F specify Cub es 2XXVo	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		4. Race - Ame Black, Whit Specify: W	
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$\mathcal{U}\mathcal{U}_{\phi}$ e, Mary	t and 2 shi deelth and tm 27 is m	K G	19a. Informant's Name/Relationship (Mary Lou Long (Si 20a. Method of Disposition		P 1		um Ri	and Number or Ru. dge Rd. F		ill,		.050
\mathcal{W}_{ℓ} Baltimor	t. Pages rtment of rtant: If ii		xt☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifical Signature of Funeral Service Licer	(y)	Holly	ery, crematory Hill M	e. Gr	dna. 9-7-	2006		timore,	
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	Physician /Medical Examiner		trimediate Cause (Final disease or condition resulting in death)	a. ACITE. Que to (or as	a consequence	ardial	Disc	tarction ease	<u></u>			
68760,	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last	c. Duno (or as	a consequence		٠					
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	the Hosp hin 24 hou the Funer npletely fil	Medical	(Check only one) Medical Exam	nysician: To the best miner: On the basis o and mannerst	of examination a	ge, death occur nd/or investiga	ition, in my o	opinion, death occur	rred at the time,	date and	place, and due	e to the cause(s)
	or with the sound of the sound	_	29b. Signature and title of certifier		//	MI	29c. Licens	006>	540	29d. Date	7-03-	2006
	Sta	10	30 Nagreyand address of person who some state of the sound of the soun	1 4000	peath (Item 23a FALK) rar's Signature	(Type, Print)	me I	or. Balt	mole.	Md	213	137
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/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town,	or Location of Death	7109. 31/	4c. County of Death	
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Funeral Director			X 7. Agg (In yrs.	Months Days	Hours Min.	8. Date of Birth Month, Day, Yea	17 Peni	place (State or Foreign ntry)
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sath w	erai [1001 Carroll Pa	12. Was Decedent Ever in U	202 217	Hispanic Origin? (Spec	Un Vac as No	14. Race - America	tates
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n "net	Completed	15. Decedent's Edi (Specify only highest grad	le completed)	16a. Decedent's Usual Occu (Give kind of work done life., DO NOT use retire	during most of working	g 16b.	. Kind of Business/In	dustry
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and 2 s and 2 s eath ar m 27 is her treu		Hattiet Palmer	e	W. 211 Sou	th St. Fre	der ck	MD 21	701
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Datifillo permit. Page Department o Importent: If eny injury or once.		*4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service License	A Al Al	22. Name and Addr	Sept.	8,206 7	rederic	K, MD
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THE SE		23a. Part . Ent - 4 disease, or comp shock, or heart failure. List only of	limitons that wased the deat ne cause weach line.	h. Do not enter the mode of dy	ring, such as cardiac or	respiratory arrest,	761 31 21	Approximate Interval Between
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nysicie nis cert direct	To B	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3 □ DOA	than 4		6 □Other (Specif	fy)
ing Phy After this		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)		ork?	3d. Describe how in	jury occurred	
Attend death ctor: y the t	ertification;	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At he	M 1 [ome, farm, street, factory, office by)	Yes 2 No		and Number or Rura	al Route Number,
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To the within To the compl	Me	29b. Signature and title of certifier	?	29c. Licen	ise number	29d. [Date signed (Month,	Day, Year)
				\mathcal{D}	93091	9	1-6-06	
4		30. Name and address of person who c	and MN	n 23a) (Type, Print) So (Tou House	e Arce,	Fred	ericle Mi
Sta Registr	_	31. Date filed (Month, Day, Year) SEP 0 6 2	32. Refistrar's Signa	H. Soule				
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2006 28107 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 08/29/2006 Alice Catherine Watkins 11:20A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dealh Examiner 5841 Pine Brook Farm Road Sykesville Carrol1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12/01/1922 Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗷 F 83 Director 217-12-7074 Usual Residence of Decedent the Maryland 10c, City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 2 No Director MD Carroll Sykesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 23a 5841 Pine Brook Farm Road 21784 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or itema filed within 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dales: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ White 3 ♥ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NDT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygieria important: If item 27 is marked other then eny injury or other traumatic access. Department of Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Motor Vehicles 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Salomon William Eastwood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code? 1784 19a, Informant's Name/Relationship (Type, Print) Gail Hallman / Daughter 5841 Pine Brook Farm Rd., Sykesville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 09/01/06 Cedar Hill Cem Baltimore, MD 21. Signature of Eneral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Ento the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) C.O.P.D **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consistuence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Cardionjopany use as the burial-transit hemic resulting in death) Last Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à page 2 should be 3 Probably 1 ☐ Yes 2 ☐ No 4 MUnknown Completed 24b. Were aulopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be 1 Yes 2 TM Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 Inpatient ပ 2 ER/Oulpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner eath 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 1 Vatural 5 Pending To the Hospital or Attendil within 24 hours after death. To the Funerel Director: Al death. investigation 1 Yes 2 No 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 296. Signature at D-0054218 39 Malcaludure, War minter 19 21157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) le Kaneur 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 6 2006 Registrar

DHMH 17 Rev 1/2001

		State of Maryla 1 - State Registrar		artment of Health an ctificate of Death		ene 2006	2810
Physicia /Medic		Decedent's Name (First, Middle, Last) Jovis Allen Wilson			2. Date of Death Month September	Day Year 3	Time of Death
Examine Funeral Director	er	4a. Facility Name (If not institution, give street all d number) LOLIFA (A) RIVERS' JR 5. Social Security Number 6. Sex 7. Age (In y	rs. last birthday) 59 Yrs.	4b. City, Town, or Location of I	1	Year) Country)	e (State or Foreigi ylvania
aryland ehow	_	Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	cation		10d.	Inside City Limits
or 28a-f	Director	10e. Street and Number	onowingo	10f. Zip Code	10	Og. Citizen of What Country	
d within 72 hours after death with the Maryland Jene. Then 'naturel', or Iteme 23e or 28e-f ehow The Medical Exertinar marke notified at	Funeral	704 McCauley Road 11. Marital Status 1 □ Never Married 2 ☑ Married 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☑ No If Yes. Give		21918 Was Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Black, White, etc.	
nin 72 hours in "natural", Medical Exe	Completed by	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+)	16a. Dece	dent's Usual Occupation kind of work done during most o DO NOT use retired)		Whi 16b. Kind of Business/Indus	
other of the	Be	9 17. Father's Name (First, Middle, Last)	Painte	18. Mother's	Name (First, Middle, M		
should and Mer s marks	To	Chester Lee Wilson 19a. Informant's Name/Relationship (Type, Print) Linda Wilson / Wife		Dorot ng Address (Street and Number of McCauley Road,		City or Town, State, Zip Co	de)
000===		20a. Method of Disposition	b. Place of Dispo cemetery, crer	osition (Name of matory or other place)	Date 2	20c. Location - City or Town Powson, Maryl	_
permit. Pag Department Important: any Injury o		21. Signature of Funeral Service Licensee		Name and Address of Facility ACCOMAS Funeral 1317 Cokesbury			d 21009
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	Completed				24a. Was ar autops perform 1 □ Yes 2	prior to completed?	findings availal letion of cause of
I or Attending Physicien: T effer death. Director: After this certificat in by the funeral director, ps	Certification: To Be	25. Was case referred to edical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 27. Mann of Death latural 5 Pending investigation 3 Suicide 6 Could not be determined.	28b. Time o Injury	ont 3 DOA Other: unurs f 28c. Injury at Work? M 1 Yes 2 No	28d. Describe ho	e) Ince 6 Other (Specify) In injury occurred The stand Number of Rural R	oute Number.
≥ 2		4 Homicide building, etc. (Sp. 29a. Certifier 1 Certifying Physician: To the best of my	ecify) knowledge, deat	h occurred at the time, date and	City or Town	n, State) ause(s) and manner as state	ed.
vithin 24 hours effective to the Funeral Directory completely filled in	Medical	(Check only 2 Medical Examiner: On the basis of exam and manner stated. 29b. Signature and title of certifier	nination and/or in	29c. License number		ate and place, and due to th	
Ų		30. Name and address of person who completed cayse of death (nD	Print) 8 Law	Street	Aberde	en,
Sta Registr		31. Dat Med (Month, Day, Year) 32. Registrar's Si	B. A	Carle	,	Mesonal PAGE CO	

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 11:SSPM 01 09 Thelma Treva Wood 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Baltimore Hospital Seint Agnes Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1□M 2\ F 82 Yrs. Director 216-20-9695 24 1923 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow other than "natural", or items 23s or 28s-f ehor 1 ☐ Yes 2 No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane 21228 USA Funerai deeth Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or iten eny injury or other treumatic event, the Mental or once. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Household Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Trail Archibald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Breman Trail / Nephew 331 High Falcon Road Reisterstown, Md 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9 7 2006 Pikesville, Md Druid Ridge Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signarure Litturarul Service Licensee 22. Name and Address of Facility Burrier-Queen Funeral Home 23a. Pa 1. E ler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Doath Immedi te Cause (Final disease x o indition resulting in death) Community Coursed **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): al Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed After this certificate has been funeral director, page 2 should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Crohn 1☐ Yes 2☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28c. Injury at Work? 28a. (ate of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1/2 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 09/01/2006 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) 900s Caton Bultimore 31. Date filed (Month, Day, Year) 32 Registrar's Signature SEP 0 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene, 28110 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 16 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner Sykesville Carroll Der 5. Social Security Number 237-20-2695 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)
 NC 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 1 ₹ M 2 □ F 91 Yrs June 11 Director Usual Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Macacal Examiner must be notified at MD Howard Columbia: 1 ☐ Yes 2 ☐ No Funeral Director 10g. Citizen of What Country? 10f. Zio Code 10e. Street and Number USA 21045 6206 Ironwood Way Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Tyes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married WWII altimore, Maryland 21215-0020 1☐ Yes 21 No Specify δ Specify: white 3 Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) policeman law enforcement 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Mitchell Welborn Perlie Mae Day 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a important: if item 27 is any injury or other training. 6206 Ironwood Way, Columbia, MD 21045 Revena DeLeonardo (niece) 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2006 North Wilkesboro, NC Mountlawn Mem. Park 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee P.O. Box 195 Sykesville, Haige Haight Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical enature Examiner Physician/Medical Examiner Hospital or Attending Physician: The lew requires that the death certificate be executed use es the bunel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) attending physician end Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ thknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 1 Yas 2 10 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 3□ DOA eral Director: After this filled in by the funeral d 27. Menne Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 1 Matural 5 Pending 1 ☐ Yes 2 🗆 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie dress of person who completed cause of death (Item 23e) (Type w gistrar's Signature 31. Date filed (Mo 32. State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SEPTEMBER REALM MARIE WICKMAN 1,2006 7:31MA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/17/1918 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🔀 F Director 88 215-03-4190 MARYLAND Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow r then "naturel", or Items 23a or 28a-f eho the Madical Examiner must be notified at Director BALTIMORE PARKVILLE 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 1708 OAKLEIGH COURT 21234 USA Pages 1 and 2 should be filed within 72 hours after death Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "naturel", or 1 Yes 2 No Specify þ 3X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 8TH GRADE other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental 27 is marked or traumatic ever JAMES L. POTTER REALM GIBBS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 le eny injury or other trau once. 21402 GUNPOWDER RD. MILLERS, MD DONNA MCKENNA/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/5/2006 METRO CREMATORY, INC. CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 8521 LOCH RAVEN BLVD. TOWSON, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CLOSTRIDIUM DIFFICILE COLITIS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed physician and resulting in death) Last Due to (or as a consequence of). burial Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death Ö the 9 Unknown signed by <u>a</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes ☐ No 24a. Was an certificate has t irector, page 2 s autopsy performed? 2 **10**0 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Inpatient ۵ 2 ER/Outpatient 3 DOA this After thi funeral of ate of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 1 X Natural 2 ☐ Accident 28d. Describe how injury occurred Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Momicide within 24 hours after To the Funaral Dire Fo the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certific 29c. License number 29d. Date signed (Nonth, Day, Year) D 24034 eted cause of death (Item 23a) (Type, Print) M. D. 7601 051

32. Registrar's Signature TIMOTHY LOW M.D. OSLER DRIVE TOWSON MARYLAND 21204 31. Date filed (Month, Day, Year) State SEP 0 Registrar

			State of Maryland / Department of Health and N State of Maryland / Department of Health and N Certificate of Death		iene g. No. 2006	28112
	Physici	an	1. Decedent's Name (First, Middle, Last) Harold G. Weeks	2. Date of Deat Month	Day Year	3. Time of Death 3.05 PM
	/Medio Examir		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1	4c. County of Deat	
			Franklin Sayuare Hospital Kosedale 5. Social Security Number 16. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.	La Data d'Alab		nore
	Funeral Director		5. Social Security Number 0. Sex 1 GM 2 F 7. s/ge (In yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Jan21,	1924	hplace (State or Foreign untry) NC
			Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
PI	Maryla -f eho	tor	MD Baltimore White MArsh			1 ☐ Yes ¾ ☐ No
Jaro	after death with the Marylan or items 23s or 28s-f show reliner mast te motified st	Funeral Director	10e. Street and Number 10f. Zip Code 21162		0g. Citizen of What Co USA	untry?
1	72 hours after death with the Maryland natural', or itema 23s or 28e-f ehow dical Exaciline intent or notified at	y Funer	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Sive 1 Yes, Sive 1 Yes, Specify Cuban, Mexican, Puerto 1 Yes, Give	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: TAT	
•	thours stural,	ed by	3⊠ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/	
ee1≺ s 21215-0036	within 72 lene. then "na	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Give kind of work done during most of work ille. DO NOT use retired)	ing F	Procter &	Gamble
		Cor	12th 17. Father's Name (First, Middle, Last) Boiler Operator 18. Mother's Name	ne (First, Middle, M	Maiden Sumame)	
ر جا ية	e d is b	To Be	Alexander Weeks Etta S	Sanders		
\mathcal{E}/\mathcal{S} \mathcal{W}			19a. Informant's Name/Relationship (Type, Print) Geneva Burger /daughter 19b. Mailing Address (Street and Number or Rur P.O.Box 126 Capon			
$y \ll M$	Pages 1 arent of Heam nt; if item ry or othe		20a. Method of Disposition 20b. Place of Disposition (Name of camptery, crematory, or other place) 4 Donation 5 Dother (Specify) 20b. Place of Disposition (Name of camptery, crematory, or other place) HOLLY HILL Cemetery9/5	Date 5/06	20c. Location - City or Baltimor	
as ko	permit. Pages 'Department of h Importent; if ite eny injury or of		21. Signature of Funeral Service Licensee Connelly Funeral Connelly Funeral			
K	HITE		23a. Part1. Enter the disease, or can fications that caused the death annot enter the mode of dying, such as cardiac shock, or heart failure. List only line cause on each line.	or respiratory arre	est,	Approximate Interval Between
10	Physician		Immediate Cause (Final disease or condition and Respiratory Arrest			Onset and Death 2 minutes
T.	/Medical Examiner		Due to (gras a consequence of):	1		one week
13	P #	Iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying	····		/
7 6	te be executed ysicien and	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Small bowel adhesions free Due to (or as a consequence of):	vious S	urgery	bmonths
8760	cate be ex physicien the buria	dical	d		•	
ajed to 48		by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of del Month	ivery Day Year
yed P.O.	that the	y Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
	equires en sign			1 □ Ye	es 2 No 3 Pr	obably 40 Unknown
A Division of Vital Record	The law r ete has be page 2 sh	Completed		24a. Was a autops perform	med? death?	utopsy findings available completion of cause of 2 □ No
/ita	ician: sertifica ector,	Be	examiner?	th (Check only on	<u> </u>	
of	Physi r this o	5.	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		ence 6 Other (Spe	cify)
no	ath. Ar: Afte	atlor	2 Accident investigation M 1 Yes 2 No			
Divis	al or Atter i efter de i Directé d in by th	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Si City or Town	treet and Number or Ri n, State)	ural Route Number,
	e Hospiti 24 hours e Funere letely fille	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	, and due to the corred at the time, d	ause(s) and manner as late and place, and due	s stated. to the cause(s)
	Withir To the comp	Ž	29b. Signature/and title of certifier 29c. License number	2	9d. Date signed (Mont	h, Day, Year)
	(10)		7) House of a page who completed course of death /lean 220/Tipe Print)		111100	
7.0	(1)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Lindsau Hoelschen, 9000 Franklin Square Drive, I	Baltimor	e, MD 2	1237
	Sta Regist	ate rar	31. Date filed (Month, Daly, Year) 32. Registrar's Signature		, ,	

		-	For State Registrar	State of N	Maryland /		artmer <i>rtificat</i>			nd Mer	ital Hygi	ene g. N2 0	06	28113
			1. Decedent's Name (First, Middle, La	st)							Date of Death		Year	3. Time of Death
	Physici /Medic		Margot W. Wilson	1							igust 1	8, 200		8:58 PM M
	Examin		4a. Facility Name (If not institution, given				4b. City,	Town, or !	Location of D	Death		4c. County		
			Hospice of the (1 Year	d If Under 24	Hrs. In	Date of Blak		e Aru	
	Funeral		,	Sex 7.7 1 □ M 2 ☑ F	Age (In yrs. last i 70	Yrs.	Months	Days		Min.	Date of Birth Month, Day, r 21,	Year) 1936	9. Birthi	place (State or Foreign ntry) inois
	Director	-	352-28-6525 Usual Residence of Decedent		70					μīα	1 219	1730		211015
buelv	Mo W		10a. State 10b. County		10c. City, To	own or Lo	ocation							10d. Inside City Limits
Na Pa	- 2	tor	MD Anne Ar	undel	An	napo	$_{ m lis}$							1 ☐ Yes 2√∑ No
ţ.	or 28	Director	10e. Street and Number				10f. Zij				10	g. Citizen of \		ntry?
ž.	23a	ai	701 Glenwood Str						21401	·			JSA	
r de	tems Fig.	Funerai	11. Maritaf Status	12. Was Decede Armed Force	s?	13.	Was Dece If Yes, spe	dent of His ofly Cuban	panic Origin I, <mark>Mexica</mark> n, F	n? (Specify Puerto Rica	Yes or No- in, etc.)		ck, White,	can Indian, etc.
0 4	o.	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 Tes 2 If Yes, Give Year or Date			1 🗌 Yes	2 <u>X</u> No	Specify:			Specif	y: whi	ite
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ה ק	Medi	pie	(Specify only highest gi Elementary/Secondary (0-12)	ade completed) College (1-40	or 5+)	(Give lif e .	kind of wo DO NOT u	ork done di se retired)	uring most o	if working				
	giene The	Completed	12	5+			ed	itor				newsp		
ביים פרות	and Mantal Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumstic event, the Madical Examiner must be notified at	Be	17. Father's Name (First, Middle, Las								rst, Middle, M		ne)	
aryla Brough	Ment	2	Alexander Lew								Tarra			
nar 2	le m		19a. Informant's Name/Relationship								oute Number,			o Code)
Baitimore, Maryland 21215-0036	t of Health and Men If item 27 le marke or other traumatic		Ruth Carper/daug	hter	20b. Place				venue	Date)iego,	Oc. Location		own. State
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	Department of Important: If eny injury or once.		4 NDonation 5 Other Spec			ا م	2 Name a	nd Address	s of Facility	.1.0	E	n - 1		74
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			23a. Pany. Enter the disease or cor	nplications that caus	sed the death. D	o not en	ter the mo	de of dying			spiratory arre	st,		Approximate
	hysician		shock or heart faifure. List only fmmediate Cause (Final		TBSTAT	10	Bas	e/pst	()	ANC	50.			Interval Between Onset and Death
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yatıla	ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
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09/8	physi	dical	•	d										
Records, P.O. Box 6	attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	me of pregnancy							23d. Da	ate of deliv	rery
Box	atter	ciar	in the past 12 months?	4□Pregnan	n 2 □ Fetal dea t at time of death		⊒Ectopic p ⊒ Other (s					Mo	onth	Day Year
o g	by the	hysi	9 Unknown	9□ Unknow	٦									
J. 5	been signed by the should be detached	by P	Part If. Other significant conditions	contributing to deat	h but not resultin	g in the u	underlying	cause give	n in Part I.		23e. Did tob	acco use con	tribute to	the cause of death?
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ř	ate ha	ĕ									perform	ed?	death?	
iga i	artitic ctor,	Be (25. Was case referred to medical examiner?					1 -		of Death (C	heck only one)		
7	This o	٦ ر	1 Yes 2 No	Hospital: 1 Inp			nt 3 D		4 🗆 14013		5 🗆 Reside			fy)
פוני	After	<u>6</u>	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of f (Month,	Day Year)	b. Time o Injury	M	28c. Injury Work	at ? ′es 2∐No		. Describe ho	w injury occui	rrea	
Division of Vital Records,	death stor:	icat	2 Accident investigate 3 Suicide 6 Could not	be 280 Place of	Injury - At home	farm st			93 2 1140		Location (Str	eet and Numi	ber or Rui	al Route Number,
	atter Direction by	Certification:	4 ☐ Homicide determine	building	etc. (Specify)	, 141111, 50		y, amo			City or Town			,
	within 24 hours alter death. To the Funeral Director: After this certificate ha	- 1		hysician: To the be										
3	n 24 l	edical	(Check only 2 Medical Exa	miner: On the basi and manner		and/or in	nvestigatio	n, in my op	inion, death	occurred	at the time, da	te and place,	and due	to the cause(s)
ļ	within To th comple	×	29b. Signature and life of certifier	M	K		29	c. License		/		d. Date signe	-	
			1/201V	Janun	~ >	m		100	81	18)	4000	572	9 2006
			30. Name and address of person who	100	. /	a) (Type	, Print)	01-	, ^		Ro 1	Anson	1011	21401
			31. Date filed (Month, Day, Year)	WAJKI	istrar's Signature	71	70	ワドラ	160	12	14)	V/1/1/6	1/101	2 410
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Sept. 2006 3:15 AM Bob Zastawski /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2256 Engle Rd. Fallston, Maryland
Under Year If Under 24 Hrs. 8. Dat
onths Days Hours Min. (Mo Harford Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral 1**∑**M 2□F Director 212-07-2866 04/18/1912 Poland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits d other then "natural", or items 23s or 28s-f showevent, the Mudical Examiner must be notified at 1 ☐ Yes 2 No Director MD Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2256 Engle Road 21047 Funeral U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 15-0036 1 ☐ Yes 2 No Specify: ģ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2121 Elementary/Secondary (0-12) College (1-4or 5+) 10 Welder Imperial Industries Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kazimierz Zastawski Julianna Janeczek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (son) 2256 Engle Foad - Fallston, Maryland 21047

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Cocation - City or Town, State Robert G. Zastawski, Jr. Itimore, 20a. Method of Disposition Pages 1 = 5 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery | 09/06/2006 Baltimore, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 6 assahn 11750 Belair Road - Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CARCINOMA OF LIVER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a surresquence of): Examiner sicien and burial-transit Due to (or as a consequence of): Physician/Medical use as the attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) o sete has been signed by the page 2 should be detached 9□ Unknown 9 Unknown ٦ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by CONCESTIVE HEART PAILURE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an PRUSTATE CANCER autopsy performed? his certificete t I director, page 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ို Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After th funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No the within 24 hours after deat To the Funerel Director: 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide 1) PCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Killianten MO D45344 30. Name and ad ress of person whether pleted cause of death (Item 23a) (Type, Print) SURESH DHANDAN, HD 622 S. UNION AVE, HAVRE DEGRACE, MOZIETA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SFP 0 6 2006 Registrar

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DHMH 17 Rev 1/2001

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State of Maryland / Department of He	ealth and Mental Hygiene 2006

		1 - For State Registrar 1. Decedent's Name (First, Middle)	Last	<u> </u>	Certificat	e or De	eatn	2. Date of De	Reg. No.		3. Time of Death
Physic			Chiekum	Asan	ga				12,200	6 Year	0100 M
/Medi Exami		4a. Facility Name (If not institution,	give street and number)		4b. City,	Town, or Lo	ocation of Death			ty of Death	
		Suburban H				thes				tgom	
Funeral Director		5. Social Security Number 219-11-3636 Usual Residence of Decedent	6. Sex 7. Ag 1	e (In yrs. last birt	frs. If Under		f Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Year) 1964	_	place (State or Foreign ntry) neroon
land ow		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
r the Marylan r 28a-f ehow	ctor		gomery	Silve	r Spri						1 ☐ Yes 2 🛣 No
th with the 23s or 2	Funeral Director	12826 Camell	ia Drive		10f. Zip	2090	5		10g. Citizen of	What Cou	
within 72 hours after death with the Maryland ene. than "neturel", or iteme 23s or 28s-f show the Mudical Exertine must be notified at	þ	11. Marital Status 1 [X] Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? ad 1 □ Yes 2 ☑ If Yes, Give Year or Dates:		13. Was Deceded If Yes, spe		anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		ice - Americack, White,	etc.
semit. Pages 1 and 2 should be filed within 72 hours att Deperment of Heelth and Mental Hygiene. Important: If Item 27 le markad other than "neturel", or nny injury,or other traumatic avent, the Moulcal Exert 2008.	Completed	15. Decedent (Specify only highest	s Education grade completed)	16a.	Decedent's Usu (Give kind of wo	al Occupation during	on ing most of worki	ng	16b. Kind of	Business/In	dustry
l withir jiene. r than	ошо	Elementary/Secondary (0-12)	College (1-4or 5	5+)	axi Dr				Taxi	Co.	
uld be filed fental Hyg rkad othe tic avent,	To Be C	17. Father's Name (First, Middle, L Alfred Nche A				18	3. Mother's Name			ime)	
permit. Pages 1 and 2 should be filed within 2 Deportment of Heelth and Mental Hygiene. Importent: If Item 27 ie markad other than "fany injury or other traumatic avent, Ite Mud one.		19a. Informant's Name/Relationsh Julius Akwani					Number or Rura		Olat	he.K	ansas
of He n		20a. Method of Disposition 1 □Burial 2 □ Cremation	3 □Removal from State	20b. Place of cemeters	Disposition (Nar y, crematory or o	me of other place)	1	ate	20c. Location	- City or To	own, State
it. Pag itment intant: njury,		4 ☐ Donation 5 ☐ Other (Sp 21. Signature Fune al Service I	ecity)	Fami	ly Ceme			9/06			ameroon
Deperment of the perment of the permet of the perment of the permet o		> Mula BX					KINALDI				
		23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that caused	the death. Do n	ot enter the mod	de of dying,	MD1a B1 such as cardiac o	r respiratory a	rrest,	prin	g, Md2091 (Approximate Interval Between
hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a Gastr	ointest	inal B						Onset and Death
Examiner	_	Sequentially list conditions,	b. Sup to for se	a consequence o	41						
nincate be executed by physicien end as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (c) as	a consaquence o							
en en		resulting in death) Last	Due to (or as	a consequence of	nf);						
physicien end s the burial-transit	Aedicai	d									
by the ettending partached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic po 5 □ Other (sp					ate of deliver	ery Day Year
igned by be deta	y Ph	Part II. Other significant condition	s contributing to death b	ut not resulting in	the underlying of	ause given i	in Part I.	23e. Did t	obacco use co	ntribute to t	he cause of death?
ite hes been signed by th page 2 should be detache	ed b	Diabetes m	ellitus					10	Yes 2√2No	3 🗌 Prob	oably 4 Unknown
age 2	omplet	Infected r	ight foot			-		24a. Was autoj perio 1 Yes	psy prmed?	Were auto prior to co death? 1 \(\text{Yes}	opsy findings available mpletion of cause of
Physician: This certificatral director, p	Bec	25. Was case referred to medical examiner?	7			2	6. Place of Death	POST OF RESIDEN			23110
this or al dire	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital:		patient 3 DC	100000	4 🗆 Nursing Hor				5 y)
) is is	tion	1 Natural 5 Pending 2 Accident investig.		y Year) 28b. T	ime of 2 ijury M	28c. Injury at Work? 1 ☐ Yes	s 2 □ No	28d. Describe	how injury occu	rred	
s after death.	Certification:	3 Suicide 6 Could n 4 Homicide determin	ot be	ury - At home, far c. (Specify)	rm, street, factor			28f. Location (City or To	Street and Nurr wn, State)	ber or Rura	al Route Number,
Hospir 4 hour Funer ely fills	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best xaminer: On the basis o and manner st	f_examination and	, death occurred Vor investigation	at the time, , in my opini	date and place, a	and due to the ed at the time,	cause(s) and n date and place	nanner as s , and due to	tated. the cause(s)
To the complet	Me	29b. Signature and title of certifier	Voont	as hi		c. License n	780		29d. Date sign		
V		30. Name and address of person w	no completed cause of c		Type, Print)			vn Rd.	- 50		d 20814
	ate	31. Date filed (Month, Day, Year)	32 Registr		Sparke						
	20.0	31. Date filed (Month, Day, Year)	32. megistr	ai s Signature	1 11 -						

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Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 28116

	F	I- For State Registrar			Cert	ificate of	Death					Reg. No	G.		
Physicia ledical Examin	n/ er	Decedent's Name (First, Middle Maximi	.no		Argue	ta				2	Date of De Month August 1	Day 1, 200		0	me of Death 045 hrs
		4a Facility Name (if not institution Prince George's Hosp		nd number)			b. City, To Cheve		cation of	Death		- 1	c. County of Prince Ge		
Funeral Director		5 Social Security Number none	6. Sex		e (In yrs. Ias 44	st birthday) Yrs.	If Under Months	_	If Under: Hours	24Hrs. Min.			,1962	9. Birthplac Foreigh 1 Courltry)	
Maryland 28a-f show any 1 at once.		Usual Residence of Decedent 10a. State 10b. County MD Char	les		10c. City, T	Town or Locati aldorf	on							1	Inside City Limits Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once	Dire	10e. Street and Number 863 Copley A	venue				10f. Zip 0	ode 060	2			-	tizen of Wha El Sa		or
r death wi or items must be	by Funeral	11. Marital Status 1 X Never Married 2 X M 3 Widowed 4 Div	arried Arm	ed Forces? es 2	X No	1 X	es, specify I Yes 2	Cuban, I E 1 S	Mexican, F Salva specify	ouerto R ado	r	lo-	14 Race - White, Specify:		ite
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours aften to Health and Mental Hygiene it: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner	Completed b	15. Decedent's Education (Specific Elementary/Secondary (0-12)		t grade com			ts Usual 0 ost of worki	ccupatio ng life, E	n (Give kir OO NOT u	nd of wo	rk done d)		Kind of Busi		•
21215-0036 Juld be filed within 7 Mental Hygiene Marked other than cevent, the Medica	Be	17. Father's Name (First, Middle, Pedro Argue)									First, Middle A Ecc		n Surname) erria	L	
MD 21 ad 2 should the and Me n 27 is ma aumatic ev		19a. Informant's Name/Relations Leonardo Argu	hip (Type, Print ieta/B	roth		863	Copl	еу	Aver		Wald	orf		land	20602
		20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other St	popy.	val from Sta		lace of Dispos rematory or oth leteri	er place) O Mu	nic	ipal			I E	l Sal	co Ca vado:	abanas,
		21. Sig Ture of Funeral Service 23a. Part I. Enter the disease, or	uld		141	PH 92	TLTP	D.I olui	RINA nbia	LDI Bl	FUNI vd.Si	ERAI	L SER	VICE	P.A. Md20910
Physician /Medical Examiner		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. Multiple	e Injuries			e mode of	aying, si	JCIT as Car	diac or	espiratory a	rrest, si	lock, or flear		proximate interval etween Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate	b		equence of)										
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8760, tificate be executed ng physician and as the burial - transit	edical	UNPENDED				inf g80	55 3-	14-0	7 v t						
as as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Uni	1	Live birth	me of pregn t time of dea	2 Fe	tal death ner (Speci	3 [Ectopic p	oregnan	су	2	3d. Date of d M onth	elivery Day	Year
P.C that s that	<u>و</u>	Part II. Other significant condit		ting to deat	th but not re	sulting in the u	inderlying o	cause giv	en in Part	I.				_	ause of death? 4 Unknown
cords law requi has been	Completed										per	s an opsy formed?	pri de		findings available etion of cause of
ital Recitions: The section, page	Be	25. Was case referred to medica examiner?	Hospital:	Innatio	ent 2	ER/Outpatient		10	of Death (Cothern		nly one)	Page	dance 6	Other:	-
Sion of Vital Attending Physician: r death ector: After this certificity the funeral director,	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pen	28a. ding Au	Date of Inju (Month, Day,) g 1, 2006	ury	28b. Time of I 1525 hrs		Bc Injury	at Work?	- [28d Describ	e how ir	dence 6 jury occurred auto collis	d	
Division Hospital or Atte 24 hours after der Funeral Directo	Certification:	3 Suicide 6 Cou	d not be		njury - At ho cal Stree	me, farm, street	et, factory,	office bu	ilding, etc.		or Town	State)	and Number		oute Number City
Divisior To the Hospital or Attenowithin 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying P	hysician: To the laminer: On the lamb		amination ar					e, and o	lue to the ca	use(s) a	and manner a	s started	
2	Me	291 Signature and title of coriffic						C.C.N					Date signed		ay, Year)
		30 Name and address of person Laron Locke MD. A	ssistant Me	edical Ex	aminer	111 Penr	Street,	Baltim	ore, MD	2120)1				
Sta Regist	ate	31. Date filed (Month Day, Year	2006	32 Registra	ar's Signatu	le for	de								

State of Maryland / Department of Health and Mental Hygien 2006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year 4:40 PM August 16, 2006 <u> Alexander Leo Anderson</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner College Park 5010 Apache St Prince Georges If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jan 23, 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □XM 2 □ F 1919 Massachusetts Director 013-14-1306 87 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f ehow rthan "natural", or Items 23a or 28a-f ehov the Medical Exeminer must be notified at 1 ☐ Yes 2 √ No Directo Maryland Prince Georges College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20740 USA 5010 Apache St Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. TYDYes 2 □ No 1942— If Yes, Give Year or Dates: 1945 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. Specify: 3√2 Widowed 4 □ Divorced 1945 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Director of Veterans Services U.S. Government rmit. Pages 1 and 2 should be filed with pertinent of Health and Mentel Hygies portant: If them 27 te marked other the yinjury or other traumatic event, Interest. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Ralph Christian Alexander Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5009 Apache St, College Park, MD 20740 Philip Anderson/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory Aug 22, 2006 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home Ola 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and D 2 hrs Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit Atherosclerotic Heart Disaese yrs and Due to (or as a consequence of): Box 68760. attending physicien for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ned by the atten detached for u 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9□ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Alzheimers Dementia, Parkinsons Disease, cete has been signated to page 2 should to 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Renal Insufficiency certificete rs after deam.
ral Director: After this ceru...
1 in by the funeral director, pr 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of gertifie 29c. License number 29d. Date signed (Month, Dey, Year) D22549 August 16, 2006 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. G. Din, MD 6510 Kenilworth Ave, Ste. 2600, Riverdale, MD 20737 31. Date filed (Month, Day, Year) State 21 AUG Registrar

DHMH 17 Rev 1/2001

	1 - For State Registrer	State of Maryland	/ Department of Certificate of		al Hygiene Reg. No. 200	6 28118
Physician	Decedent's Name (First, Middle, Las REBECCA ABENA	AMOAH		M		3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution, give DOCTORS 1 COMMUNITY HO	street and number)	4b. City, Town, LANHAN	or Location of Death	4c. County of PRINCE G	Death
Funeral Director		ox 7. Age (In yrs. las ☐ M 2[X]F 88	t birthday) If Under 1 Year Months Days	Hours Min. (M		. Birthplace (State or Foreign Country) GHANA
death with the Maryland ma 23a or 28a-f ehow Irmust be notified at person Director	Usual Residence of Decedent 10a. State 10b. County MARYLAND PRINCE GEO	-	Town or Location W CARROLLTON			10d. Inside City Limits 1 Yes 2 No
with the Mar with the Mar as or 28s-f el	10e. Street and Number 6803 GOOD LUCK ROAI)	10f. Zip Code	0784	10g. Citizen of Wha	at Country?
036 Urs after urs after the control of the control	3 XWidowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Hispanic Origin? (Specify Y ban, Mexican, Puerto Rican,	es or No- 14. Race -	American Indian, White, etc. BLACK
n 72 h	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire HOMEMAKER	during most of working	16b. Kind of Busin	,
nd 2 be filed all Hygi dother went, II	17. Father's Name (First, Middle, Last)		IIO ILI PIKLIK	18. Mother's Name (First AKLVA GYAM	, Middle, Maiden Sumame)	
2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	19a. Informant's Name/Relationship (TREBECCA FREMPONG - DA				e Number, City or Town, Sta DLLTON, MD 20874	te, Zip Code)
Baltimore, N permit. Pages 1 and: Department of Heelth Important: If them 27 any jointry of ther them 27 any jointry.	20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 🖄 4 □ Donation 5 □ Other (Specify,	Removal from State OSII	e of Disposition (Name of etery, crematory or other pla CEMETERY	Date UNK	20c. Location - Cit	y or Town, State GHANA
Balt permit Depart Import any inj	21. Signature of Funeral Service Licens	500			INALDI FUNERAL H	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and property Medical Certification: To Be Completed by Physician/Medical Examiner		a. SEPS/. Due to (or as a consequer Due to (or as a consequer Due to (or as a consequer	S T/ON F (CO Of): (CO OF):	ONE UMI	ONIA	Approximate Interval Between Onset and Death 10 Days 12 Days 12 Days.
P.O. Box 6E nat the death certifica by the attending pt letached for use as at	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Ø No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death 9 Unknown	ath 3 Ectopic pregnand	:y	23d. Date o Month	f delivery Day Year
COrds, P		ntributing to death but not resulting	ng in the underlying cause gr	ven in Part I. 23	3e. Did tobacco use contribu	te to the cause of death? □ Probably 4 □Unknown
Division of Vital Records, I or Attending Physician: The law requires that after death. Director: After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed by					autopsy prior deat	e autopsy findings available to completion of cause of h? Yes 2 \(\text{No} \)
Vita	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 □ ER	/Outpatient 3□ DOA Ot	26. Place of Death (Chec		
ision of Vita Ntending Physician: death. ctor: After this certific y the funeral director. flication: To Be			b. Time of 28c. Injury Wo		☐ Residence 6 ☐ Other (escribe how injury occurred	Specify)
Division c tal or Attending P is after death. al Director: After led in by the luners Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office	28f. Lo Cri	cation (Street and Number of ty or Town, State)	r Rural Route Number,
DIN To the Hospital or a within 24 hours after To the Funeral Dire completely filled in b	one)	sicien: To the best of my knowle iner: On the basis of examination and manner stated.	and/or investigation, in my	opinion, death occurred at th	ne time, date and place, and	due to the cause(s)
or 3	29b. Signature and title of certifier	Jamalu 1	29c. Licen.	se number 821	3 8/16 Kwy Green	fonth, Day, Year)
	30. Name and address of person who co			lanover P	KWY Green	belt MD
State Registrar	31. Date filed (Month, Day, Year) AUG 21 20	32 Jegistrar's Signature	Sparke			

William Hank Bakleren 06-05877 Please Type or Print in Black Indelible Ink **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day August 8, 2006 Medical Examiner William Hanks Balderson 0758 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Route 50 at Chateau Road Cambridge Dorchester 5. Social Security Number 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Director Months Days Hours 215-58-5553 1 XM 56 2 F Jan. 8. 1950 CountryMaryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov or items 23a or 28a-f show must be notified at once. 1 X Yes 2 No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 202 White Ave. 21224 USA Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. other than "natural", or items: 14 Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married White etc. 2 X No Yes Widowed Divorced If Yes, Give Year white 1 Yes 2 X No specify: Specify: "natural", ģ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 x-ray technician 2 should be filed within and Mental Hygiene. health care 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit Pages I and 2 should be file Department of Health and Mental II Important: If item 27 is marked of Be traumatic event, William N. Balderson Bertha Kuebler ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Jackson p.r. 505 Roslyn Ave., Cambridge, MD 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State Salisbury Crematory 8/18/06 Salisbury, MD Other Specify Donation 5 22. Name and Address of Facility Thomas Funeral Home P.A. fire of Funeral Service Licenses 700 Locust St., Cambridge, MD 21613 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical a Contact Shotgun Wound of Head Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 3 phy 23c. If ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Fetal death Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 23e Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes No Fo the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other, Scene 1 🗸 Yes No After . Manner of Death 28a. Date of Injury FOUND: 28b. Time of Injury 28d Describe how injury occurred 28c. Injury at Work? Certification: Subject shot self Natural FOUND: Pending Yes 2 🗸 No Director: Aug 8, 2006 0758 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be within 24 hours al To the Funeral L determined (Specify) Park/Recreation Area Route 50 at Chateau Road, Cambridge, MD Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started **Medical**

Registrar DHMH 17 Rev 1/2001

OCME 2006

State

29b Signature and title of certifie

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner

ORIGINAL

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

August 9, 2006

	1 - For State Registrar			. That y latte				Death	Mental F	Reg. I	F3 (3 (16	2812
Physician		ne (First, Middle, La:	•						2. Date of Month	Death		ear	3. Time of Death
/Medical	ALICE	LEE	BYRNE						AUGU	ST .	17 200		10:00 AM
Examiner		(If not institution, give						Location of De	ath	1	4c. County of		
_	5. Social Security	caster Mil					ockv	ille If Under 24 H				ntgon	
eral ctor	212-12- Usual Residence	-1163 ¹	ex □ M 2 (3 -F	. Age (In yrs. Ia	Yrs.	Months	Days	Hours M		Day, Yea	1922	Birthpla Country Mary	ce (State or Foreigr 7) 7land
	10a. State	10b. County		10c. City,	Town or Lo	cation						100	f. Inside City Limits
ţ	Md.	Montgo	mery		Silve	er Sp	ring						1 Yes 2 No
Funeral Director	10e. Street and No. 15915 Z	umber attleboro	Road			10f. Zip	p Code	20905		10g. (Citizen of Wha		
Jera	11. Marital Status		12. Was Deced	ent Ever in U.S	. 13.	Was Dece	dent of Hi	spanic Origin?	(Specify Yes or erto Rican, etc.)	No-	14. Race -	American	n Indian,
by	1 Never Mar	ried 2 to Married 4 □ Divorced	Armed Ford 1 ☐ Yes 2 If Yes, Give Year or Dat	. ⊠No	1	f Yes, spe 1 🗌 Yes	/	n, Mexican, Pu Specify:	erto Rican, etc.)		Specify:	∨hite, et Wh	ite
Completed	(Sna	15. Decedent's Ed	lucation		16a. Dece	dent's Usu	al Occupa	ation		16b.	Kind of Busin	ess/indu	stry
nple	Elementary/Sec		College (1-	for 5+)				ation furing most of v)	vorking			1	
S	12				Bus	Driv	er					ubli	c School:
0		(First, Middle, Last) Ce Jackso		son				18. Mother's N	ame (First, Mide beth W		en Sumame) Pirce		
4	19a. Informant's N	lame/Relationship (7	Type, Print)		19b. Mailir	ng Address	s (Street a	and Number or	Rural Route Nur	nber, City	or Town, Sta	te, Zip C	ode)
		lwin Byrne	sr./Ht		1591	5 At	tlebo	oro Roa	d, Silve	er Sr	ring,	Md.	20905
5	20a. Method of Dis	position Cremation 3	Damoval from St	20b. Pla	netery, crei	sition (Name	me of other place	9)	Date	20c.	Location - Cit	y or Town	n, State
	4 Donation	5 Other (Specify	Nemoval IIom 31	Pa	rklawr	Cem	etery	7 8	/21/06	Ro	ckvill	e, M	id.
To B	21. Signature of F	neral Service Liben	350	M-004	22				r Funera , Laytor				0882
ਕੁ ਹੋ ਤ clan/Medical Examiner	disease or condition resulting in death) Sequentially list or any, loading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)	enditions, non-adiata erlying injury	b. Due to (or	as a conseque as a conseque as a conseque	ence of):	Lung	Cand	cer					
Physiclan/Med	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	months?		h 2 ∏ Fetal d it at time of dea	leath 3 [Ectopic pr					23d. Date of Month	delivery Da	ay Year
þ	Part II. Other signi	ficant conditions co	ontributing to dea	th but not result	ing in the ur	iderlying c	ause give	n in Part I.		tobacco			cause of death?
Completed									24a. W		24b. Were	autopsy	r findings available
ő									рө	formed?	deat	1? Yes 2[
Be	25. Was case references	/ +						26. Place of D	eath Check on				
ျှ	1 Yes 2 2 27. Manner of Dear 1 Natural	140	28a. Date of		R/Outpatien 8b. Time of Injury		A Other	4 🗀 Nul Sing	Home 5 ☐ Re 28d. Describ			Specify)	Hospice
Certification:	2 Accident 3 Suicide	investigation 6 Could not be determined	28e. Place of	Injury - At hom	e, farm, stre	М	1 🗆 Y	es 2 No	28f. Location	(Street a	and Number o	r Rural R	oute Number.
	4 Homicide			, etc. (Specify)					City or 7	own, Sta	te)		
Medical	(Check only one)	1☑ Certifying Phy 2☐ Medical Exam	iner: On the basi and manner	s or examinatio	n and/or inv	estigation,	at the time , in my opi	e, date and place inion, death occ	ce, and due to the curred at the time	e cause(e, date ar	s) and manne nd place, and	r as state due to the	ed. e cause(s)
Σ	29b. Signature and	title of certifier	m.m.	111	- I		License	number 0580 5	7		ate signed (M		,
	1	ess of person who d					1700	1000	_		August	17,	2006
		M. Willia					er Mi	ll Road	, Rockv	ille	, Md.	208	55
State egistrar	31. Date filed (Mon	ug 21 2	32 Aeg	istrar's Signatu	And And	we							

			1 - For State Registrer	State of M	aryland / Dep <i>Ce</i>	ertificate of			giene Reg. No. 20	06	28121
			1. Decedent's Name (First, Middle, Li	ist)				2. Date of De	ath		3. Time of Death
Н	Physic /Medi		Gustavo Sastr	ano Bela	val			Month August	. 16, 20	Year 06	11:40 a M
	Exami		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town,	or Location of D		4c. County		
			17708 Georgia A	venue			Olney			Mont	gomery
	Funeral		Social Security Number 6.	Sex 7. Ag	e (In yrs. last birthda)) If Under 1 Year	If Under 24		th Your	9. Birth	place (State or Foreign
	Director		497-24-9203	1 🛣 M 2 🗆 F	88 Yrs.	Months Days	Hours	Min. (Month, Da Sept. 3			erto Rico
	D .		Usual Residence of Decedent								
	aryla hov	_	10a. State 10b. County		10c. City, Town or I	ocation					10d. Inside City Limits
	88-1	Sch	Maryland Montgo	nery	01	ney					1 Tes 28 No
	ith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	intry?
	within 72 hours after death with the Maryland ene. then "natural", or Iteme 23a or 28e-f ehow he Medical Exeminer must be netitied at	La La	17708 Georgia A	venue		20832	2			USA	
	teme	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent of I If Yes, specify Cub	Hispanic Origin an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	- 14. Rac	e - Amer	can Indian,
36	or l		1 ☐ Never Married 2 ☑ Married	1 X Yes 2 ☐ If Yes, Give	No			uerto Rica		v: Whi	
8	ural'	d b	3 Widowed 4 Divorced		1951-76				0,000,00		
21215-0036	nat	Completed by	15. Decedent's E (Specify only highest gi		(Giv	edent's Usual Occup e kind of work done	during most of	working	16b. Kind of B	usiness/li	ndustry
2	Mithir The n	E E	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retire					
7	Hygie ther nt,		17. Father's Name (First, Middle, Las			Physici		None (First Middle		Medi	cal
au	ntail od o	Be	Armando Belaval	,			To. Mother's	Name (First, Middle,		•	
Ë	d Me d Me nark natio	은		T 0:-1				Maria Ter			
Maryland	12 st h and 7 le r		19a. Informant's Name/Relationship	Type, Print)	19b. Mai	ing Address (Street	and Number o	r Rural Route Numbe	ər, City or Town,	State, Zi	p Code)
	Tealt and the the		Diana A. Belava 20a. Method of Disposition	l/ Wife	20b. Place of Disp	8 Georgia	Avenue	e, Olney,	Marylan		
ŏ	20 = 00 P		1 Surial 2 ☐ Cremation 3 [Removal from State	cemetery, cre	ematory or other pla		ctober 11	20c. Location -	City or T	own, State
Baltimore,	in the part of the		4 □Donation 5 □Other (Speci	* .		National Ce	metery	2006			Virginia
ga	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Iteme 23a or 28a-1 ehow and injuly go other treumatic event, the Madical Examiner must be natified at once.		21. Signature of Funeral Service Lice	nsae O	F	Pancis Adre	ess collin	ns Funeral	Home I	nc.	
	40 = • a		Muchle	Jule						ring	, MD 20901
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cluse on each li	I the death: Do not er ne.	nter the mode of dyir	ng, such as car	diac or respiratory ar	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Gastri	c Cancer						Onset and Death 2 Years
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):						
	LAGITITIE	_	Sequentially list conditions,	U	ryngeal Dy	sphagia					1 Week
	D H	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):						
	and tran	саш	Cause (Disease or injury that initiated events resulting in death) Last	c							
50,	clan	Ê		Due to (or as	a consequence of):						
8760	icate be executed physician and s the burial-transit	dlcal	•	d							
9	ling p	Me	IF FEMALE:								
Box	death certifi e attending I id for use as	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnancy	,			e of deliv	
o.	0 0	sic	1 Yes 2 No	4☐Pregnant at 9☐Unknown	time of death 5	Other (specify)			Moi	าเก	Day Year
<u>.</u>	The law requires that the site has been signed by the page 2 should be detached.	Physician/Me									
Ś.	res th	Ď	Part II. Other significant conditions								he cause of death?
Ö	w requir been si should I	ted	Coronary Artery [oisease, De	eep Venous	Thrombos	is,	_ 1 Y	es 2LXNo	3 □ Prol	pably 4 □Unknown
e C	law lasb	Completed	Diabetes Mellitus	, Renal In	nsufficien	cy, Anemi	a	24a. Was autop	an 24b. V	Vere auto	ppsy findings available impletion of cause of
I		8						pertor	rmed?	leath?	
Vital Records,	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?				26. Place of I	Death (Check only or			
<u>o</u>	Physic this co	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpatie	nt 3□ DOA Oth	er: 4 Nursin	g Home 5 Resid	lence 6 Othe	er (Speci	(۲)
	ding Ph h. After th funeral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	Year) 28b. Time o	of 28c. Injur Wor	y at	28d. Describe h			
<u>0</u>	Attending ir death. ector: After by the funer	att	2 ☐ Accident investigatio	1			Yes 2 □No				
DIVISION	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ury - At home, farm, st	reet, factory, office		28f. Location (S City or Tow	Street and Number	er or Rura	al Route Number,
	ital c rai D rai D										
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Ornock Orn) Z Intouteal Exal	niner: On the basis of	of myknowledge, dear	th occurred at the tir	ne, date and pl	ace, and due to the o	cause(s) and ma	nner as s	tated.
	the I the F	led	,	and manner sta	ited.			Country at the time, t	and and place, a	iniu uue t	o tile cause(s)
	To To	Σ	29b. Signature and title of certifier	Q . 1		29c. Licens	e number 5956	2	29d. Date signed		
1	11		/ / anon	morle	ne	04	2936		Augu	ıst]	.8, 2006
4	2T		30. Name a Laddress of person who								
			Dawn Asano Broder			ince Phil	ip Driv	e, #225, (Olney, N	1D 20	0832
	Sta	te	31. Date filed (Month, Day, Year)	. Gegistra	r's Signature			117	The state of the s		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200628122 For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year John Earl Bell August 19 2006 6:52 p. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1402 Race St. Cambridge Dorchester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 6 Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 M 2□F Hours Director 213-24-2278 Yrs 29, 1928 Maryland Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "nature" ery hijury or other traumatic every note. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Dorchester 1'XYes 2 No Directo Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1402 Race St. 21613 Completed by Funeral USA 12. Was Decedent Ever in U.S. Amed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1954-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 1954-58 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) machinist wire cloth mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Henry Bell 2 Mary Melvina Bromwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Bell wife 1402 Race St., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Memorial Park 8/24/06 | Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician schemic resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of The law requires that the death certificate be executed ettending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death signed by the e 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should 1 tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 4 No director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No the 2 ☐ Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 \ Homicide ō To the Hospital o within 24 hours aff To the Funerel DI completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D57040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

BRIENDON

32. Registrar's Signature

105 AURORA

P.O. Box 68760,

Records,

Division of Vital

ST.

CAMBREDGE, MD

Amended Item 4a per Physician 08/23/2006 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.2 () () 6 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Doroth 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Longview Nursing Home Munchester Carroll 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours Min. (Month, Day, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Months Days 380240 235 Yrs. Director WV Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maximal Exerciting the notified at once. MD Carroll Finksburg 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2400 Kays Mill Road 21048 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ¾☐ No Specity: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Clothing Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Manufacturing 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be J. C. Lancaster Eva Walker ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles T. Bradley - Husband 2400 Kays Mill Rd., Finksburg, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 TCremation 3 ☐ Removal from State Carroll Cremations 08-24-06 Hampstead, MD 21074 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee 100550 934 South Main St., Hampstead, MD 21074 olana Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebrovascu Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 42 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 23/ 06 0 aced L. Ru 40061206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Pogistrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

AUG 23

2006

State of Maryland / Department of Health and Mental Hygiene Rag. NO 0 6 1 - For State Registrar 28124 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Auq 16 2006 1845 Physician Phyllis Hope Conner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Feb 6 1929 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ F Maryland 220-66-8802 77 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County in than "natural", or items 23e or 28e-f show Calvert. Maryland Prince Frederick 1 TYPS 2 NO Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5255 Sixes Road 20678 United States death v Funeral permit Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Importent: if them 27 is marked other them any injury or other trainments. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: white Specify: ğ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker 12th own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Parran Buck Sarah Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Beth Ogle- daughter 5255 Sixes Rd. Prince Frederick, MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Asbury Cemetery Aug 19 2006 Barstow Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS STUDROME 3 DATS **Physician** disease or condition resulting in death) /Medical Examiner DIVERTICULITI 3-4 DA11 ACUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as as JE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð PENAL FAILURE, HYDERTENSION 1 Yes 2 40 3 Probably 4 Unknown Completed PERPHERAL VAJCULAR DISFAST 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page ARAHYTHM 145 certificate 1 ☐ Yes 2 ☐ No 2 110 To the Hospitel or Attending Physiclen: 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No P this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: / d in by the f 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 126.758 address of person who completed cause of death (Item 23a) (Type, Print) PRINCE FREDERICK MD-20678 WEIGEL JO H 32. Registres Signature 31. Date filed (Month, Day, Year) State AUG 22 2006 Registrar

			State of Maryland / Department	partment of F ertificate of			ene 2006	28125
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Virginia He	len Crei	ghton	2. Date of Death Month Aug 17	Day Yeer 2006	3. Time of Death 8 PM M
	Examin		4a. Facility Name (If not institution, give street and number) Bayside Nursing Home		r Location of Death		4c. County of Death St. Mar	
4.	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda $216-80-5688$ $1 \square$ M $2 \square x$ 86 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(ear) 9. Birth Co.	iplace (State or Foreign intry)
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Maryland Calvert Lusby	Location				10d. Inside City Limits 1 Yes 2 No
	a with the	i Director	10e. Street and Number 13312 Rousby Hall Road	10f. Zip Code 20657			g. Citizen of What Cou	•
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f ehow other traumatic event, the Medical Examinar must be notified at	by Funerai		3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	dispanic Origin? (Spe an, Mexican, Puerto I Specify:	city Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
21215-0036	d within 72 ho piene. r than "natur rha Medical	Completed	(Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occup ive kind of work done a. DO NOT use retired nemaker	pation during most of workin d)	ng 10	own home	
Maryland 3	ould be filed Mental Hygid arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) Joshua Clyde Humphreys		18. Mother's Name Blanche		,	
	and 2 should ealth and Men n 27 Is marke		19a. Informant's Name/Relationship (Type, Print) Florence Ledford- daughter 107	illing Address (Street O Cape S	and Number or Rura t. Mary	Route Number,	City or Town, State, Zi Mechanic:	sville MD
Baltimore,	Page nent c ant: If ary or		1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Middle	_	el Aug21	2006	oc. Location - City or T Lusby Ma:	ryland
Balt	permit. Departr Importa eny Inji		21. Signature of Furneyal Service Licensee	22. Name and Addre	es of Facility Rau	sch Fu	neral Hon rt Repub	me lic MD 206
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	Nerste mode of dyin lary to tive HEA any As	ng, such as cardiac of active of the Frank lary L	Personatory arres	it.	Approximate Interval Between Onset and Death Williams Constitution of the Constitution
Box 68760,	eath certificate be executed attending physicien and for use as the burial-transit	dicai	in the past 12 months:	3 □Ectopic pregnancy	,		23d. Date of deliv	very Day Year
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Ö	e Hospital or Attend 24 hours after death 5 Funeral Director: etely filled in by the i		4 Homicide determined building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, de			City or Town,	State)	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated. 29b. Signature and title of pertitier	investigation, in my o	pinion, death occurre	ed at the time, dat	e and place, and due	to the cause(s)
	F 3 F 8		> James JarloEH	DD	06419	>	8-18-0	06
			30. Name and address of person who completed cause of death (Item 23a) (Type Torbot Cause of John Cause Ca	e how	nerdto	wn h	70	
10000	Sta Registr		31. Date filed (Month) Jay, Year) 31. Registres Signature AUG 2, 2 2006	Sperti				

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State of Maryland / Department of Health and Mental Hydiene?

		1	For Stata Registrer	State of Ma	ryland / Di	epartment of Certificate of	f Death	Ra	g. No.	28126
	Physicia		1. Decedent's Name (First, Middle, Last Phyllis Pata		hran			2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al -	4a. Facility Name (If not institution, give		III all	4b. City. Town.	or Location of Death		13, 2006 4c. County of Dea	9:40
	Examin	er	9524 Colesville				er Spring		Mont	gomery
	Funeral Director		5. Social Security Number 6. S		(In yrs. last birth	Months Day		8. Date of Birth (Month, Day, Dec. 12,	Year) C	rthplace (State or Foreign ountry) nnsylvania
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	ith the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C USA	
	s 23a		9524 Colesville	Road 12. Was Decedent E	ver in 11 S	13. Was Decedent o	20901 Hispanic Origin? (S	pecify Yes or No-	14. Race - Am	
320	be filed within 72 hours after death with the Maryland la lytygene. do thy than "natural", or items 23a or 28a-f ahow do ther than "natural", or items 23a or 28a-f ahow event. It a Maciful Examiner is ust be notified at	by Funeral	11. Marital Status 1 □XNever Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:		13. Was Decedent o		o Rican, etc.)	Black, Who	
ş	72 hou		15. Decedent's E	ducation	1	Decedent's Usual Occ Give kind of work don	ne during most of wor	rking 1	6b. Kind of Business	-
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N	t. Led		17. Father's Name (First, Middle, Last	5+		Teacher	18. Mother's Nar	ne (First, Middle, N		CHOOLS
Maryland 2	d be fi	o Be	Bernard W. Coch					ie E. Mc		
37	shoul nd Me mark	2	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Stre	et and Number or Ru	ıral Route Number,	City or Town, State,	Zip Code)
re, Ma	permit. Pages 1 and 2 should be fill Department of Health and Mental H Important: If itam 27 is marked out any injury or othar traumatic evan once.		Claire C. Flaher 20a. Method of Disposition		20b. Place of	11 Shady I Disposition (Name of crematory or other p		Date 19,	SVIIIe. V	20155 or Town, State
Ē	Page nent c		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special Control of Co		Gate of	Heaven Cemet	tery 200	6 :		ring,Maryland
Baltimore,	permit. Departr Import any inj		21. Signature of Funeral Service Lice		1	22. Name and Add Francis J 500 Unive				
		N I	23a. Parti. Enter the disease, or conshock, or heart failure. List only	nplications that caused one cause on each lin	the death. Do no e.	ot enter the mode of o	tying, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death
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	/Medical Examiner		1630tting in doubt)	Due to (or as a	a consequence o	f):				
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Ω.	res that the de signed by the a l be detached f	y Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlying cause	given in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
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Division of Vital Records,	fhe law require te has been sig age 2 should b	Completed						24a. Was a autops perform	ned? prior to death'	
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)ivisio	or Attand liter death Diractor: , in by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not determine	be 290 Place of Ini		rm, street, factory, off		28f. Location (St City or Town	treet and Number or n, State)	Rural Route Number,
L	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certilicate ha completely filled in by the funeral director, page	Medical Ce	29a. Certifier 1 Certifying F (Check only one)	Physicien: To the best eminar: On the basis of and manner sta	examination an	, death occurred at the	e time, date and plac ny opinion, death occ	e, and due to the courred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	o tha	Me	29b. Signature and the of certifier	1		29c. Lic	ense number	2	9d. Date signed (Mc	onth, Day, Year)
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	10		30. Name and address of person wh				Pland Who	aton MD		
			Cheryl Ayleswor 31. Date filed (Month, Day, Year)			niversity	DIVG, Whee	acon, MD	20302	
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State of Maryland / Department of Health and Mental Hygien 2006 28127 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Buruan Cabrera 3. Time of Death 2 Date of Death Eduardo Month AUGU **Physician** 2145 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY ff Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 20, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 58 Yrs. Birthplace (State or Foreign
Country) **Funeral** 1948 1**X** M 2 ☐ F 551 93 3675 Director Yrs. Philippines Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Exactor must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Silver Spring 3802 and Number 10f. Zip Code 10g. Citizen of What Country? 238 8302 Kelsey Street 20906 Philippines within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. , or itame Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: Filipino Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify þ 3 Widowed 4 Divorced Asian "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. other than 4 Baker Bakery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental Important: if Item 27 is marked o Pedro Manguilic Cabrera Gloria Bolton Bunuan 3802 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Maria Wilma Luz Cabrera/Wife intury arether 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition August 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 18,2006 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Francis J. Collins Funeral Home, Inc. 500 University Blvd., West, Silver Spring, Maryland 21. Signature of Funeral Service Licenses 20901 any ir mun Hint. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical (ardiovasurlar 1)isease Examiner therosclerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of): burial-Division of Vital Records, P.O. Box 68760, attending physicien ician/Medical the SE IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death esn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached Physi 9 Unknown 9 🗌 Unknown been signed to should be deta Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? After this certificate has director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident death investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funerel I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier icai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MSICIAN completed cause of death (Item 23a) (Type, Print) 30. Nameland ad 1. Date filed (Month, Day, Year)

NIG 18 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

2006

06-06403 Michael Caine

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

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4	U	U	U	4	U	I	4	U

		1- For State Registrar	Ce	rtifica	ate of Death	ntai nygiene		200	6 2812
Physi	ciar	1. Decedent's Name (First, Middle,	Last)			2. Date of E	Reg N	lo.	
Medical Exa	min	TITCHACT OCEDI	en Cain			Month August		Year	3 Time of Death 1632 hrs
pr.a.		4a. Facility Name (if not institution, 3310 Oberon Street	give street and number)		4b. City, Town, or Location	of Death		4c. County of Deat	1
Farmer		5.0			Kensington		1	Montgomery	
Funera Directo		200 60 000	Sex 7. Age (In yrs.			der 24Hrs. 8. Date of	Birth(M	M/DD/YYYY) 9. Bi	rthplace (State or
			X M 2 F	54	Yrs. Months Days Hour			Forei	gn puntryMaryland
япу		Usual Residence of Decedent 10a. State 10b. County	10a Cit.	T					
*	الا	,	Toc. City	, rown c	or Location				10d. Inside City Limits
Maryland 28a-f show	{	Maryland M 10e. Street and Number	ontgomery		Kensington				1 Yes 🐒 No
ith the Maryland 23a or 28a-f sho	Director	2210 01- 0			10f. Zīp Code		10g. C	itizen of What Cou	ntry?
with t	1 2		12. Was Decedent Ever in U	<u> </u>	20895			USA	
leath ritem	Funeral	1 Never Married 2 Marri	ed Armed Forces?	.5	 Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican 	gin? (Specify Yes or I n, Puerto Rican, etc.)	No-	14. Race - Ameri White, etc.	ican Indian, Black,
after o	: I	[2 \\/idowed 4 \A\n.	1 Yes 2 X No	J	1 Yes 2 X No specify:				
5-0036 led within 72 hours a Hygiene other than "natura the Medical Examin	E	45 Deceded 5 5 11 15 15		16a D	ecedent's Usual Occupation (Give	kind of work done	16h	Specify: Whit	
6 172 h an "n cal E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	dı	uring most of working life. DO NOT	use retired)	160.	Kind of Business/I	ndustry
within iene ien th	E		5+	Acc	ountant		I	rinancial	Management
15-1 filed I Hyg	Į č		st)		18.Mother	's Name (First, Middle			
ID 21215-00; should be filed within and Mental Hygiene 7 is marked other till and event, the Mental Hygiene water water water with a manual ma	o Be		(T)		Loµise	D. Rada			
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland this and Mental Hygiene n 127 is marked other than "natural", or items 23a or 28a-f she ammatic event, the Medical Examiner must he anotified at a comment of the short of the state of the short of t	Ĕ			19b.	Mailing Address (Street and Num	ber or Rural Route No	umber, C	city or Town, State,	Zip Code)
		Neil A. Cain/ Sc 20a. Method of Disposition	On I 20h E	451	4 Muncaster Mill Disposition (Name of cemetery, J	Road, Ro	ckvi	lle, MD	20853
nore, MD 2 ages I and 2 shount of Health and I it: If item 27 is rother traumatic		1 Burial 2 X Cremation 3	Removal from State	remator	y or other place)	Date August 29	20c.	Location - City or	Town, State
Itin		4 Donation 5 Other Special 21. Signature of Funeral Service Lice		oboT1	tan Crematory	2006	h 1 a	vandria	Virginia
Baltimore, permit. Pages I and Department of Heal Important: If item injury or other tra		1 10	ensee		22 Name and Address of Eacility	ins Funer	al H	lome Inc.	virginia
Physician	_	23a. Firt I. Enter the disease, or comfail re. List only one cause on e	oplications that caused the death	Do not e					g, MD 20901
/Medical					site friede of dying, such as ca	ardiac or respiratory ar	rest, sho	ock, or heart	Approximate Interval Between Onset and
Examiner	ı	Immediate Cause (Final disease or condition resulting in death)	a. Acute Alcohol In Due to (or as a consequence of	toxic	ation				Death
		Sequentially list conditions,)						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of)	:					
_ +	xam	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of)						
18760, rrificate be executed ing physician and as the burial - transi		d							
be experient	n/Medical	X UNPENDED	AMENDED item#28f,	perM	E,g860, 10/6/06 TT 28a-f,perME,g859,9/2	25/25			
8760, tificate be ng physicial as the buria	/Me	IF FEMALE: 23b. Was decedent pregnant in the	y	ancy	28a-1, penyll, g859,9/	26/06 TT	220	Date of delivery	
30x 687 death certifit e attending for use as t	siciar	past 12 months?	1 Live birth 4 Pregnant at time of dear	do =	Fetal death 3 Ectopic	oregnancy		Month Da	y Year
Box te death c the atten ted for us	ıysi	1 Yes 2 No 9 Unknow	9 Unknown	5	Other (Specify)				
ch th	/ Phys	Part II. Other significant conditions	contributing to death but not res	ulting in	the underlying cause given in Part	1 230 Did to	hassa		211111111111111111
ires that	d by				, , , , , , , , , , , , , , , , , , , ,			No. 3 Probab	e cause of death?
i of Vital Records, ing Physician: The law require After this certificate has been si uneral director, page 2 should b	Completed					24a Was			
Reco	崩					autop		prior to con death?	psy findings available inpletion of cause of
	ပ္	25. Was case referred to medical				1 ✓ Yes			2 No
Vital system: this certif director,	O B	evaminor?	lospital: 1 Inpatient 2 E	R/Outna	26 Place of Death (C				
n of ding Ph	盲	27. Manner of Death			of Injury 28c. Injury at Work?	Vursing Home 5 28d. Describe h		nce 6 Other: S	cene
	ertification:	Natural 5 Pending Accident Investigation			4:20 pm 1 Yes 2 X N			y occurred	
VISION AL	<u>i</u>	Accident Investigation Investi		e, farm,	street, factory, office building, etc.	THE THE PARTY		d Ni	
Divi		4 Homicide determined			, , , , , , , , , , , , , , , , , , ,	Kensington	ate) 3	10 Oberon	Route Number, City Street
e Hos 124 h e Fun letely		29a. Certifier 1 Certifying Physici.	an: To the best of my knowledge,	death o	ccurred at the time, date and place	and due to the	119 111		
Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certificompletely filled in by the funeral director,	- G		On the basis of examination and and manner stated	or inves	tigation, in my opinion, death occur	red at the time, date a	nd place	manner as started e, and due to the cr	ause(s)
1	Σ	29b Signature and title of certifier			29c License number			ate signed (Month,	
20 2		Paret Porthall. n.	<i>(1)</i>		O.C.M.E.			st 27, 2006	ouy, real)
264		30. Name and dress of person who c							
			sistant Medical Examine		1 Penn Street, Baltimore, I	MD 21201			
Sta Registi	te	31. Date filed (Month Cay Year) 20	32 Registrar's Signature	So	well .				
HMH 17 Pay 1/20	04		The same of	3					

DHMH 17 Rev 1/2001

Registrar

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State of Maryland / Department of Health and Mental Hygiene o o c

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			1 - For Stete Registrer			Cer	tificate o	f Deat	h	ioniari	Reg. No		16	28131
P	Physici	an	Decedent's Name (First, Middle, La	st)						2. Date of De Month	eath Da	ıy	Year	3. Time of Death
	/Medic		HARRIETT ELIZ		NA					AUGUST	14	20	006	8:15 PM
	Examin	er	4a. Facility Name (If not institution, giv				4b. City, Town				40	. County		
			MONTGOMERY GENERAL 5. Social Security Number 6.5		e (In yrs. last	hirth day)	If Under 1 Yea	OLNEY or If Und	er 24 Hrs.	8 Date of Bi	dh		OMERY 9 Bight	
- 10 - 10 - 10 - 10	Funeral Director			1 M 2 M F	85	Yrs.	Months Day		s Min.	8. Date of Bi (Month, D SEPTEMBE	ay, Year, ER 30	, 1920	NEBR	place (State or Foreig ntry) ASKA
	land land		10a. State 10b. County		10c. City, T	own or Lo	cation						1	10d. Inside City Limits
	Mary -feh	tor	MARYLAND MONTGOME	RY		SIL	VER SPRIM	IG						1 ☐ Yes 2 🔯 No
	r 28a	Director	10e. Street and Number				10f. Zip Code				10g. Ci	itizen of W	hat Cour	ntry?
	h with	ai D	1507 INTERLACHEN ROA	AD, #221				20908				U.S	S.A.	
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Slatus 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 If Yes, Give	1 ☐ Yes 2 🕅 No If Yes, Give		Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Yes 2 No Specify:			ecify Yes or N Rican, etc.)	0-	Specify:		etc.
2-003a	hour tural		15. Decedent's E	Year or Dates:	1 1	6a Docor	lent's Usual Occ	unalion			16b k	Cind of Bu		WHITE
C1717	within 72 iene. then "na he Wedic	Completed	(Specify only highest gra	Colfege (1-4or 5		(Give lite. L	kind of work dor OO NOT use ret	ne during m ired)	ost of work	ing	PRI		ORGE	S COUNTY
2	i Hyg other	a	17. Father's Name (First, Middle, Last						ther's Name	e (First, Middle	1			
2	lid be fenta rked ric ev	To B	JENS PETER HANSON	Ň					CARR	IE ELIZA	BETH .	ANDERS	ON	
	should be and be and the semanticular th	j	19a. Informant's Name/Relationship (1	19b. Mailin	g Address (Stre	et and Num						Code)
≥	and 2		JAMES P. CASTAGNA -	SON	:	1045 W	INDRUSH I	ANE, S	ANDY SI	PRING, MA	ARYLA	ND 208	60	
5	Tien C		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Bomoval from State	20b. Place ceme	e of Dispos etery, crem	sition (Name of natory or other p	lace)	1	Date	20c. L	ocation - (City or To	own, Slate
Ĕ	Pag ment ant: I		4 Donation 5 Other (Special		GATE (VEN CEMET		8/17/2					MARYLAND
Daillinor	permit. Departimport any inj		21. Signature of Funeral Service Lice	nsee	-i	22	. Name and Add	ress of Fac HAMPS	HIRE AV	NES-RINAI VENUE, SI	LDI F	UNERAL SPRIN	HOME G, MA	E, INC ARYLAND 2090
00/00,	Physician /Medical physician up bhysician and bhysician and sas the prinal-transit	Medicai Examiner	Immediate Cause (Finaf disease or condition resulting in death) Sequentially fist conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as Due to (or as Due to (or as d.			force							Onset and Death
-	To the Hospital or Attending Physicien: The law requires that the death certification 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 manths? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. ff yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetaf dea	ath 3 🗌	Ectopic pregnar					23d. Date Mon		ery Day Year
ecolds, r	uires that signed t	ρ	Part II. Other significant conditions of Renal Four		ut not resultin	g in the ur	nderlying cause	given in Par	rt I.					he cause of death?
5	w req beer shou	Completed								24a. Was	an .	24h W	lere auto	psy findings available
ב ב	he la e has ige 2	ш								auto		pr	nor to con eath?	impletion of cause of
Ilai	ifficate or, pe	ပိ	25. Was case referred to medical					De Die	as of Donat	1 Tes	2010	11	☐ Yes	2 No
>	s cert direct	0 8	examiner?	Hospital: 1 Inpatie	ent 2 TEB/	Outpatien:	3 DOA			me 5 Res		6 DOtho	r (Specifi	
VISION OF	nding Phy tth. :: After thi e funeral	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Dale of Inju (Month, Da		b. Time of Injury	28c. In			28d. Describe				7)
	or Atternation of Directors	ertification:	3 Suicide 6 Could not be determined		ury - At home c. (Specify)	, farm, stre	eet, factory, offic	е		28f. Location (City or To			r or Rura	al Route Number,
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	edicai C	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exam	nysician: To the best niner: On the basis o and manner sta	examination	dge, death and/or inv	occurred at the restigation, in my	time, date y opinion, d	and place, eath occurr	and due to the ed at the time,	cause(s , date an	and mar d place, a	ner as st	lated. the cause(s)
	To th within To th	Me	29b. Signature and title of certifier				29c. Lice	nse numbe	r		29d. Da	ite signed	(Month,	Day, Year)
	11		> Cluston	servers			D :	3979	3		Au	genst	15.	,2006
	4		30. Name and address of person who		eath (Item 23	a) (Type, I	Print) MER PO	.7		a.1				670
			Christopher-J		181	11 80	ince pl	nlie	DO INE	2,011	oy,	mo	24	2632
	Sta	6	31. Date filed (Month, Day, Year)	JZ. BOIST	ar's Signature		.0							

Registrar DHMH 17 Rev 1/2001 AUG 2 1 2006

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Please Type or Print in Black Indelible Ink

inifer Clayton		State of Maryland / Department of Head 1- For State Certificate of Dead Registrar	ath	Reg	_{9. No.} 2006 2813
Physicia dical Exami		Decedent's Name (First, Middle,Last) Jennifer Michele Clayton		2. Date of Death Month August 17,	2006 Year 2226 hrs
			timore City		4c. County of Death
Funeral Director		, , , , , , , , , , , , , , , , , , , ,	- In 11 Inc	8. Date of Birth Apr 10,	(MM/DD/YYYY) 9. Birthplace (State or Foreign New Country) Jersey
land f show any once.	or	10a. State 10b. County 10c. City, Town or Location Maryland Carroll	Uniontow		10d Inside City Limits 1 Yes 2 No
vith the Maryland s 23a or 28a-f show a	I Director	3411 Uniontown Road	Zip Code 21158		g Citizen of What Country? USA
ifter death wit it", or items 2 ner must be n	y Funeral	1 Never Married 2 Married Armed Forces? If Yes, specifies	dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto R		14. Race - American Indian, Black, White, etc White Specify:
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once.	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	al Occupation (Give kind of wo vorking life. DO NOT use retire nce Teacher		16b. Kind of Business/Industry School
, MD 21215-0036 and 2 should be filed within 72 lealth and Mental Hygiene ten 27 is marked other than 'tranmatic event, the Medical	Be Com	17. Father's Name (First, Middle, Last) Frederick Testa		ne Gail	Sanforo
MD 21. Id 2 should be a should be an in 27 is mar	Tol	Michael A. Clayton, husband 3411 Un	iontown Road,	Unionto	
Baltimore, MI permit Pages 1 and 2 s Department of Health at Important: If item 27 injury or other tranm		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State South Carroll 4 Donation 5 Other Specify:	Crematory 08	721 006	20c. Location - City or Town, State Winfield, MD
		Justi R. Durboraus 91			boraw Funeral Home Inster, MD 21157
Physician /Medical Examiner	/	23a Fart I. Enter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple Injuries Due to (or as a consequence of):	e of dying, such as cardiac or i	respiratory arres	st, shock, or heart Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of).			
e executed cian and rial - trans	Medical E	d. UNPENDED AMENDED			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		су	23d. Date of delivery Month Day Year
P.O. E that the d ned by the detached	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part I.		pacco use contribute to the cause of death? 2 V No 3 Probably 4 Unknown
Division of Vital Records, P.O. rate or Attending Physician: The law requires that the rafter death. The Insertion: After this certificate has been signed by led in by the funeral director, page 2 should be detact	Completed			24a. Was ar autops perform	24b. Were autopsy findings available prior to completion of cause of death?
Vital Recysician: The his certificate director, page	o Be C	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3	26.Place of Death (Check or DOA Other Nursing		Residence 6 Other:
ion of Virtending Physiceath. tor: After this the funeral dir		27. Manner of Death 1 Natural 5 Pending Aug 17, 2006 2 Accident Investigation		PBd. Describe ho	ow injury occurred uck by car
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined 2Be. Place of Injury - At home, farm, street, factor (Specify) Local Street 29a. Certifier 1 Could its Physician To the house for uncould do the coursed of	c	or Town, Sta lear Ridge I	Road north of Green Valley , New W
Fo the Havithin 24 Fo the Fu	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated	my opinion, death occurred at		nd place, and due to the cause(s)
MIN	Ź	Mount In The Shell	O.C.M.E.		29d. Date signed (Month, Day, Year) August 20, 2006
10		30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn S	Street, Baltimore, MD 2	1201	
S Regis	tate trar	31. Date filed (Month, Day, Year) ALLG 2 2 2006 32. Registrar's Signature			
DHMH 17 Rev 1/2		ORIGINAL			

State of Maryland / Department of Health and Mental Hygiene 200628132 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 18, 2006 Robert Jerome Clark, Sr. 4:55 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb 5, 1929 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**2** M 2□ F 212-26-9584 77 Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Westminster Maryland Carroll 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1237 Brehm Road 21157 usa 238 or Itsms 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No þ Specify white 3 Widowed 4 □ Divorced "natural" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Board of Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Maintenance Education espartment of Health and Mental Hygis Important: If Item 27 is marked other transmingth injury or other transmins. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Leon Clark Lucress Speight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Clark, Jr., son 5531 Windsor Mill Road, Baltimore, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 08/22 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2006 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Fugaral See M01191 91 Willis Street, Westminster, MD 21157 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the American physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Detail death 3 Ectopic pregnancy cate has been signed by the atte-page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Yes 4b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 1 Yes 2 No 2 after death.

Diractor: After this certified in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury investigation 1 TYes 2 TNo 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 10 and a tress of person who completed cause of death (Item 23a) (Type, Print) Attac MD filed (Month, Day, Year) State 2006 Registrar

For State Registrar State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician Betty Α. 2006 Crum 7:45 A M 18 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 53 Maple Avenue Walkersville Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Year, Hours 1 ☐ M 2 🖾 F 220-28-2958 Yrs Director 73 11. 1932 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "naturel", or Items 23a or 28a-f show other treumatic event, the Micrical Examinar must be notified at 1 X Yes 2 No Marvland Frederick Walkersville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 53 Maple Avenue 21793 United States death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No White Specify: ģ Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "nu eny Injury or other treumatic event, Ite Media once. Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alfred Clinton Denn Gertie May Eyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard M. Crum / Husband 53 Maple Avenue Walkersville, Maryland 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State August 21, Glade Cemetery 4 Donation 5 Other (Specify) 2006 Walkersvulle, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 40 Fulton Avenue Walkersville, Maryland 21793 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive Heart Failure 3 Years resulting in death) /Medical Due to (or as a consequence of) Examiner Pulmonary Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner the death certificate be executed signed by the attending physicien and d be detached for use as the burial-transit Aortic Stenosis resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical Chronic Kidney Disease IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2⊠No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24a Wasan 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No certificate Division of Vital 1 ☐ Yes 2 🔯 No Hospital or Attending Physicien: in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death After Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 XNatural death. 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 24 and manner stated. within 2 To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dev. Year) euner D41619 August 18, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 63 Thomas Johnson Drive Frederick, Maryland 21702 Michael A. Lerner, M.D.31. Date filed (Month, Day, Year) State Registrar AUG 2 3 2006

State of Maryland / Department of Health and Mental Hygiene 2006 28134 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 9:20 PM Jane Elizabeth Carbaugh August 2006 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept. 21, Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Director 213-16-0857 82 Yrs. 1923Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 2 should be most and and the state of theme 23s or 28s-f show is marked other then "naturel", or iteme 23s or 28s-f show wanted event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland | Frederick Frederick 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 1421 Taney Avenue Apt. #125 21702 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify à 3 XWidowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Welder Air Pax 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be ind Mental Frederick Nicholas Shankle Anna Esther Fogle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if item 27 is m any njury or other traum once. Joan Shaw / Daughter 5601 Hines Road, Frederick, Maryland 21704 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 8/22/06 Smithsburg, Maryland 21. Signature of Emeral Service Licens ROBERT ACTORS OF FILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CORDINARY ARTERY DISEASE **Physician** /Medical Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical ettending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery The law requires that the death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Year 4☐Pregnant at time of death signed by the e 5 Other (specify) o. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ KIPMEY STAGE 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Yes EMINYSEMA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy perform certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending death. To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and 29d. Date signed (Month, Day, Year) 0060764 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRANISCAV FOM ING, MD, 172 THOMAS DOHNSON 31. Date filed (Mont) DEG State Registrar

DHMH 17 Rev 1/2001

06-06034 Sarah Dykstra

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 28135

		Registrar		Ce	ertificate c	or Death				g. N o.		
Physicia Medical Exami		1. Decedent's Name (First, Midd Sarah S. Dy	kstra					/	Date of Deat Month August 14,	Day Ye 2006		3. Time of Death 0812 hrs
		4a. Facility Name (if not instituti Peninsula Regional M		umber)		4b. City, Town, o Salisbury	or Location o	of Death		4c. County Wicomi		
Funeral Director		5. Social Security Number 579-94-4419	6. Sex	7. Age (In yrs.		If Under 1 Ye Months Da		Min.	8. Date of Birt	,	Y) 9. Birti Foreigi Cou	hplace (State or "Washington
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be motified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State De. Suss 10e. Street and Number 9585 Cedar La 11. Marital Status 1 Never Married 2 X M	Sex ane 12. Was De Armed File 1 Yes 1 Yes	cedent Ever in Corces? 2 X No er de completed)	y, Town or Local Part of the American Science of the A		dispanic Originan, Mexican, Mexican, Mexican, do specify: ation (Give left DO NOT left D	gin? (Speci Puerto Rick kind of work use retired s Name (Fi 15an S	ify Yes or No- can, etc.) k done) irst, Middle, M Smith	USA 14. Rac Whi Specify: 16b. Kind of B Veteri daiden Surnam Stewart ber, City or To	e - Americ te, etc. Whi usiness/Ir nary	10d. Inside City Limits 1 Yes 2 X No http? Can Indian, Black, te Industry /Hospital end
Baltimore, Nepermit. Pages I and Department of Healti Important: If item injury or other tran		20a. Method of Disposition 1 Burial 2 Crematic 4 Donation 5 Other S 21. Signature of Funeral Service	on 3 X Removal f Specify: e Licensee	rom State	Place of Dispo crematory or c ray Roa 22.	osition (Name of c	emetery, ery ss of Facility Short,	Aug. 2	24, 200 aroon I	20c. Location Unio 6 Nova	on Ce Scot	entre,
Physician /Medical Examiner	ľ	23a. Part I. Enter the disease, of failure. List only one cause Immediate Cause (Final diseas or condition resulting in death)	or complications that one on each line. e a. Multiple In	caused the deat	th. Do not enter	the mode of dyin	g, such as ca	ardiac or re	espiratory arre	est, shock, or he	eart	Approximate Interval Between Onset and Death
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Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to cone) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated.										
An.	Ž	29b/Signature and title of certifi	ier				.M.E.			29d. Date sign August 15		nth, Day, Year)
60,0		30. Name and address of perso								- Mugust 10	, 2000	
1			Assistant Medica	4		n Street, Balt	imore, MI	D 21201		_		
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			For State Registrar		f Marylan	d / Depa	artment of H rtificate of L	ealth and Death		gien e Reg. No.	006	281	36
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	Examin	er	4a. Facility Name (If not institution 10948 Whiterim	Drive			4b. City, Town, or Potomac			Mon	unty of Death tgomery		
	Funeral Director		5. Social Security Number 126-64-0004 Usual Residence of Decedent	6. Sex 1 AM 2 □ F	7. Age (In yrs. 72	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi		y, Year)	Cour		Foreign
	Maryland f show	ō	10a. State 10b. County MD Montg			y, Town or Lo					1	0d. Inside Cit	-
	with tha la or 28a-	Director	10e. Street and Number			· ocomer	10f. Zip Code	20854		-	of What Cour	•	
036	d within 72 hours after death with tha Maryland Jone. r then "naturel", or Items 23a or 28a-1 show the Macinal Examinational benefits of at	by Funeral	10948 Whiter 11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	ried Armed Fo	2 ፭¥ No ∕e		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 1 No	spanic Origin?	(Specify Yes or No erto Rican, etc.)	1	Race - Americ Black, White, ecify: Whit	etc.	
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	nd 2 sho alth and I 27 is ma ir treume		19a. Informant's Name/Relations Larisa Dubrovs		nter		ng Address <i>(Street a</i> B Whiteri					Code)	
Baltimore,	Pages 1a		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 □Removal from	State 20b. P	lace of Dispo emetery, crer	sition (Name of natory or other place	9)	Date	20c. Locat	ion - City or To		
Balt	permit. Pages 1 and 2 should ba filed will be partiment of Health and Mental Hygien Importent: If item 27 is marked other the eny injury or other treumetic event, the page.		21. Signature of Funeral Service		W	22	con Cemet Name and Addres	is of Facility J	oseph Gav	ler's	Sons	Inc.	
	8		23a. Part1. Enter the disease, shock, or heart failure. List Immediate Cause (Final		•	h. Do not ent	er the mode of dying	g, such as cardi	ac or respiratory a	rrest,		Approximate Interval Bety Onset and D	veen
	Prrysician /Medical Examiner		disease or condition resulting in death)		(or as a conseq		Carcinor	na of th	ne Bladde	r			
8/60,	cate be executed physician and the burial-transit	Ical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	C	(or as a conseq								
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VII	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:			Othe	N 67	eath (Check only o				5.50
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	To the Hospital or I within 24 hours after To the Funeral Dirac completely filled in D	edical	29a. Certifier 1 X Certifyii (Check only one)	ng Physician: To the Examiner: On the b and man	best of my kno asis of examina ner stated.	wledge, death tion and/or inv	occurred at the tim vestigation, in my op	e, date and plac sinion, death oc	ce, and due to the curred at the time,	cause(s) and date and pla	d manner as st ice, and due to	ated. the cause(s)	
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6	20		30. Name and address of person	-						0	11/0	<u> </u>	
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Out of the Madical Family of Marial Hygiene. Narked other then "neture hatic event, the Madical E To Be Completed	17. Father's Name (First, Middle, Last) John A. Evans	4			Nellie	e F. Poole	e	
for regard regions about the mean within received and desir must be avaigned out the strength of the strength and Mental Hygiene. Ordant: If item 27 is marked other then "neturel", or iteme 23e or 28e-f ehow injury or other traumatic event, the Medical Examiner must be notified at the strength of the	19a. Informant's Name/Relationship (T) Paula H. Marshall 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	/companion	4165 Place of Disposit	Meadowb	oridge Ro	l., Salish	City or Town, State, 2 Oury, MD 2 Oc. Location - City or Salisbury,	1804 Town, State
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rtificete hes tor, page 2 t	25. Was case referred to medical				26. Place of Dea	autopsy perform 1 Yes 2 th (Check only one	ed? death?	
ath.r. After this cerrie funeral direct	examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	dospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	3 DOA Othe 28c. Injury Work	#∐ Nursing ⊓	ome 5 Resider 28d. Describe how	nce 6 Other (Spec	cify)
To the negoties or tandarding rejectant, the within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page. Medical Certification: To Be Com	3 ☐ Suicide 6 ☐ Could not be determined 29a. Certifier 1 ☐ Certifying Phy	28e. Place of Injury - At h building, etc. (Speci	fy) owledge, death o	occurred at the tim	e, date and place	City or Town,	use(s) and manner as	stated.
within 24 hours from Fune Completely fil	(Check only 2 Medical Exeminate one) 29b. Signature and title of certifier	ner: On the days of examinating manner stated.	ation and/or inve	29c. License	number	rred at the time, da	d. Date signed (Monti	to the cause(s)
State Registrar	Joseph Raffett 31. Date filed (Month, Day, Year)	mpleted cause of death (Itel	2//0// sature	57. S	uli sbur	y MD	8 22 6 (

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 28138

1- For State Registrar	Certifi	cate of Death	Re	eg. No.	
1. Decedent's Name (First, Middle,Last)	DV GD		Date of Deat Month	h 3. Time o	
		4b. City. Town, or Locati		, 2000	TIFS
		Salisbury		Wicomico	
214-28-1887 X					
Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	vn or Location		10d. Insid	le City Limits
MD Worceste	r Pocom	oke City		1 X Ye	es 2 No
10e. Street and Number		10f. Zip Code	10	-	
203 Payne Ave.		21851		USA	
	12. Was Decedent Ever in U.S. Armed Forces?			 14. Race - American Indian White, etc. 	, Black,
3 Widowed 4 Divorced	f Yes, Give Year	1 Yes 2 No spe	cify:	Specify: White	
15 Decedent's Education (Enceity only				16b. Kind of Business/Industry	
Elementary/Secondary (0-12)	College (1-4 or 5+)		o i do i o i i o d j	Maitanana	
17. Father's Name (First, Middle, Last)	IMI		ther's Name (First, Middle, N		
Paul Eby		El	sie Yoder		
		- ,			′ I
20a. Method of Disposition				20c. Location - City or Town, Stat	
1 X Burial 2 Cremation 3	Removal from State Firs	t Bapt. Cem.	08/28/06		
	ee e	22. Name and Address of Fa	l cility 103 Trinde	en Ave . Pocoi	moke,
mikel DDo	un			110 •	21851
failure. List only one cause on eac	h line.			Betwee	mate Interval in Onset and
-		sclerotic cardiovasc	ular disease co	mplicated by drownin	geath
Sequentially list conditions, b					
cause. Enter Underlying Cause	ue to (or as a consequence of).				
(Disease or injury that initiated events resulting in death) Last	ue to (or as a consequence of):				
d	AMENDED				
IF FEMALE:	item#1.23a	<u>,27,28a-f, perME,g8f</u> ;y	0,10/4/06 TT	23d. Date of delivery	
23b. Was decedent pregnant in the past 12 months?	1 Live birth		opic pregnancy	Month Day	Year
1 Yes 2 No 9 Unknown	9 Unknown	5 Other (Specify)			
	contributing to death but not result	ting in the underlying cause given in			
			autop	sy prior to completion	
		OC Plans of D			2 No
examiner?	ospital: 1 Inpatient 2 ✔ ER	- lother		Residence 6 Other:	
27. Manner of Death		o. Time of Injury 28c. Injury at W		now injury occurred	
1 Natural 5 Pending 2 X Accident Investigation	8/23/2006 3	:40 pm 1 Yes 2			
3 Suicide 6 Could not be	e 28e. Place of Injury - At home	, farm, street, factory, office building	g, etc. 28f. Location (S	Street and Number or Rural Route I tate) Public Landing/	Number, City Wharf
4 Homicide		death occurred at the time, date and			
one) 2 Medical Examiner:	On the best of my knowledge, on the basis of examination and/or and manner stated.	r investigation, in my opinion, death	occurred at the time, date	and place, and due to the cause(s)	
	and manner states.	29c. License num	ber	29d. Date signed (Month, Day, Ye	ear)
29b. Signature and title of certifier	0// /05				
Le lusa Paraxi	edles.	O.C.M.E.		August 24, 2006	
Me lusa Arasu 30. Name and address of person who co	1.00		ore MD 21201	August 24, 2006	
	1. Decedent's Name (First, Middle, Last) SAMUEL MARION E 4a. Facility Name (if not institution, give reninsula Regional Medical 5. Social Security Number 214-28-1887 Usual Residence of Decedent 10a. State 10b. County MD Worceste 10e. Street and Number 203 Payne Ave. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Last) Paul Eby 19a. Informant's Name/Relationship (Tyr. Grace Eby / Wife 20a. Method of Disposition 1 Namial 2 Cremation 3 4 Donation 5 Other Specify: 21. Signature of Funeral Service License or condition resulting in death) Sequentially list conditions, if any, heading to immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, heading to immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, heading to immediate Cause (Pinal disease or condition resulting in death) Sequentially list conditions, if any, heading to immediate Cause (Pinal disease or condition resulting in death) Sequentially list conditions, if any, heading to immediate Cause (Pinal disease or condition resulting in death) Sequentially list conditions, if any, heading to immediate Cause (Pinal disease or conditions of the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 4 Homicide 27 Manner of Death 1 Natural 5 Pending 28 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide 4 Homicide 4 Conditions Investigation Could not be determined	1. Decedent's Name (First, Middle, Last) SAMUEL MARION EBY, SR. 4a. Facility Name (if not institution, give street and number) Peninsula Regional Medical Center 5. Social Security Number 214-28-1887 Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow 10c. Street and Number 203 Payne Ave. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (17 Ves, Give Year 15. Decedent's Education (Specify only highest grade completed) 16. Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Last) Paul Eby 19a. Informant's Name/Relationship (Type, Print) Grace Eby / Wife 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 1 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 1 Due to (or as a consequence of): 23a. Part I. Enter the disease or condition resulting in death) 3 AMENDED 1 Tenter (1) Licensee 23c. Marked 25b. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined 26a. Castificer.	1. Decedent's Mame (First, Middle, Last) Paul Eby 10. State Biducation (Specify only highest grade completed) 11. Marital Status 1 Never Married 2 X Married 15. Decedent's Education (Specify only highest grade completed) 16. Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Paul Eby 192. Informant's Name (First, Middle, Last) Paul Eby 193. Informant's Name (First, Middle, Last) Paul Eby 194. Informant's Name (First, Middle, Last) Paul Eby 195. Decedent's Education (Specify only highest grade completed) 185. Pearl Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a fairly, leading to indicate events resulting in death) Sequentially list conditions. 1 NumPenDed 1 Yes 2 No 99 Unknown Part II. Other significant conditions 1 NumPenDed 1 Natural S Pending 2 Name of Death 2 Name of Injury Set. Plury at W. (Morth, Day, Yes) 2 Name of Death 2 Name of Injury Set. Plury at W. (Morth, Day, Yes) 2 Name of Death 2 Name of Injury Set. Plury at W. (Morth, Day, Yes) 3 Suided 6 Could not be determined Vereiffed of Name of Injury Set. Plury at W. (Name) 2 Pending 2 Name of Death 3 Natural S Pending 4 Hornicide 2 Name of Death 4 Hornicide 2 Name of Death 3 Natural S Pending 4 Hornicide 2 Name of Death 4 Hornicide 2 Name of Death 3 Natural S Pending 4 Hornicide 2 Name of Death 4 Hornicide 2 Name of Death 4 Hornicide 2 Name o	1. Decedent's Name (First, Middle, Last) SAMUEL MARION EBY, SR. 4a. Facility Name (if not institution, give street and number) Peninsula Regional Medical Center Social Security Number 214 − 28 − 1887 Name 2	SAMUEL MARTION EBY, SR. 44. Facility Name (I not institution, gre areset and number) Peninsula Regional Medical Center 5. Social Security Number 6. Sex 21.4 – 2.8 – 18.87 7. Ago (in ye. less birtholy) Yes 7. Ago (in ye. less birthol) Yes, parkly Cabas, Maletan Yes, parkly Cabas, Melance, Plens Rean Yes Yes, parkly Cabas, Melance, Plens Rea

State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Mary 120 /Medical 4a. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Cambridge 210 Crusader Road Apt. 603 Dorchester If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F Director Yrs. 79 Jan. 213-22-5264 10, Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r then "netural", or items 23s or 28s-f ehor the Medical Examinar must be notified at MD Dorchester Cambridge 1 ¥Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 210 Crusader Road Apt. 603 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: ģ Specify: white 3 Widowed 4 □ Divorced "netural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any linury or other traumatic event ODEs. Be Harry Walter Dunn Mary Hubbard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Bayview Ave., Cambridge, MD Stephen R. Elzey 21613 son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Dorchester Memorial Park 8/21/06 Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD $\mathcal{N}\gamma\gamma$ 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heperteusian **Physician** Vois /Medical Due to (or as a consequence of): Examiner Rheumatoid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a Id be detached f o. 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Onknown should b Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes → APA No certificete hes tirector, page 2 s Division of Vital To the Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home SAResidence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation s effer dea. Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours eft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12110 215541welth MD. afferding Physica 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 402 Byrn St., Cambridge, MD Vinodrai Mehta M.D. 21613 31. Date filed (Month, Day, Year) State AUG 2 2 2006 Registrar

DHMH 17 Rev 1/2001

Aı	nenc	ded ite	em	State of Maryland / Department of He Registrar #28c, per physician, 8/23/06, Certificate of D		ental Hygi WCHD	iena nne	
•				1. Decedent's Name (First, Middle, Last)	Jean	2. Date of Deatl	-	3. Time of Death
		Physici	ian			Month	Day Yea	ar A4
		/Medi Examir		John P. Faucett 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or L	Location of Death	8	17 20 4c. County of D	06 0425 [™]
		Lxaiiii	iei	Atlantic General Hospital Berlin			Worcest	
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
2		Director		489-48-5199 60 Yrs.	Hours Will.	2/9/194	46	OH
0		pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
240		with the Maryland a or 28a-f show Le notified at	5					1 ☐ Yes 2X No
2		28a-	Director	MD Worcester Berlin 10e. Street and Number 10f. Zip Code		10	ng. Citizen of What	Country?
()	with Ba or	2					Country
		ns 23	Funerai	36 Birdsnest Dr. 21811 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of His If Yes, specify Cuban.		cify Yes or No-	USA 14. Race - A	merican Indian,
	(0	r iter	Figure	1 Dever Married 2 TX Married 1 TXYes 2 DNo		Rican, etc.)	Black, W	
	93	all, o	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 🛣 No Year or Dates:	Specify:		Specify:	White
	2-0	72 ho natur	Completed	15. Decedent's Education 16a. Decedent's Usual Occupat (Specify only highest grade completed) (Give kind of work done du	tion uring most of working	20	16b. Kind of Busine	ss/Industry
	2	man and	npie	Elementary/Secondary (0-12) Cotlege (1-4or 5+) life. DO NOT use retired)	g	.9		
9	2	led w lygier her th		4 Owner/operato		(F) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Gift and	Floral
46	and S	be fi	Be		18. Mother's Name	(First, Middle, N	Maiden Sumame)	
1	<u>Z</u>	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than " traumatic event, the Med	2	Thomas Richard Faucett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Information Address)	Ruth P		City - To - Ct-1	7:0:11
9461/60/20	Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene importants if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Evantimer must be notified at once.		0.11			10000	a, Zip Code)
2	e)	1 an Heal Hem 2		Gail Faucett (wife) 36 Birdsnest D 20a. Method of Disposition (Name of	D		1811 Oc. Location - City	or Town, State
,	no	ages ont of t: if it		1 ☐ Burial 2 XCremation 3 ☐ Removal from State cemetery, crematory or other place)	l l			
0	Baltimore,	artme ortan injur		`4 □ Donation 5 □ Other (Specify) Cape Henlopen Crem 21. Signature of Funeral Service Licensee 22. Name and Address	of Facility The	/2006	Frankfo	rd, DE
D. U. B.	B	Depariment Department		108 Willia				Home
~				Sa Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.				Approximate
		Physician		Immediate Cause (Final				Interval Between Onset and Death
		/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	- CAN	rev	-	
		Examiner		Sequentially list conditions				
		₽ #	ner	if any, leading to immediate Due to (or as a consequence of):				
		and trans	Examiner	that initiated events c.				
6	760,	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit		Due to (or as a consequence of):				
7		physic the t	dical	d				
3-5	9 ×	certifica Iding ph	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				
48	Вох	death of attended for us	Physician/Med	in the past 12 months?			23d. Date of o	Day Year
6	o.	the d	ysic	1 Yes 2 No 9 Unknown 9 Unknown				
684	م.	requires that the een signed by th nould be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	n in Part I.	23e. Did toba	acco use contribute	to the cause of death?
State.	rds,	quires n sign	d by			1 ☐ Yes	s 2□No 3□	Probably 4 ZUnknown
2			Completed			24a. Was an	24b. Were	autopsy findings available
10	α	The lay	E			autopsy perform	ed? death	o completion of cause of ? es 2 No
2		Physician: Th this certificate al director, pag	a	25. Was case referred to medical	26. Place of Death			85 22 110
eH	>	Physician: this certific ral director,	To B	examiner? 1 Yes 2 No	4 Nursing Hon	ne 5 Resider	nce 6 Other (S)	pecify)
00		ding Pt		27. Manner ol Death 1 S Natural 5 Pending (Month, Day Year) 28b. Time ol 28c. Injury a Work?	at 2	8d. Describe how	w injury occurred	
th	Sio	Attsnding r death. actor: After by the fune	catl	2 ☐ Accident investigation M 1 ☐ Ye	es 2 KNo			
	Division	or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	8f. Location (Str. City or Town,		Rural Route Number,
		urs a urs a eral D		CO. Codifica Division Tolland				10
		Hos 24 ho Fun Fun	edical	29a. Certifier (Check only one) (Check only one) (Check only one)	e, date and place, a nion, death occurre	nd due to the car id at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
		To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Med	29b. Signature and title of certifier 29c. License r	number	29	d. Date signed (Mo	nth, Day, Year)
		- s - ō		4000	(2445)	1	un et i	7 2.00/
	7	01.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0 3110	71	0903/ /	1000
8	5	3+1		29 Broad ST BERLYN MD 21813	3 The	omas l	_u besk	· /
		Sta		31. Date liled (Month, Day, Year) 32. R histrar's Signature				
		Registr	ar	AUG 2 3 2006 Jean & Spark				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

artinent	011	16 aiti i	anu	MICHILA
rtificate	of	Dogth	2	

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	Fun		
W.	Dire	ctor	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Itame 23s or 28s-1 show any injury or other traumatic event. The Medical Examiner must be notified at Odge.

Helen Ferrand

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

1 - State Registrar	Co	ertificate of De	Reg. h	Reg. No 2006 28141				
Decedent's Name (First, Middle, Last)			2. Date of Death	of Death 3. Time of Death				
Helen E.	Fer	rand	1	· ·	19. 2006	7:30PM		
4a. Facility Name (If not institution, give street and numi		4b. City, Town, or Loc			c. County of Death			
SALISBURY REHAB & NURSIN		SALISBURY,			WICOMICO			
5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F 7 Usual Residence of Decedent	. Age (In yrs. last birthda 91 Yrs.	Months Days H	ours Min.	3. Date of Birth (Month, Day, Yea 8-31-1914	ur) Coun	lace (State or Foreigi try) ylvania		
10a. State 10b. County	10c. City, Town or	Location			1	0d. Inside City Limits		
MD Wicomico	Salisb	oury				1 ☐ Yes 2X No		
10e. Street and Number 1401 Glen Avenue		10f. Zip Code 21804		Citizen of What Coun USA	try?			
11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes, Grey 2 ☒ Widowed 4 □ Divorced 12. Was Deced Armed Force 1 □ Yes 2 17 Yes, Grey Year or Dat	es? ! X No	3. Was Decedent of Hispa If Yes, specify Cuban, N 1 ☐ Yes 2X No S	rfy Yes or No- ican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	4or 5+)	cedent's Usual Occupation ve kind of work done durin b. DO NOT use retired)	g most of working	7	Kind of Business/Inc	dustry		
17. Father's Name (First, Middle, Last)	H	lomemaker 18.		First, Middle, Maide	Own Home en Sumame)			
Jesse Edgar Fulmer	10h 14-	siling Address (Street s = 1	Mae Llev		or Tour Ct. T	Codel		
19a. Informant's Name/Relationship (Type, Print) Jeffrey Ferrand – son 20a. Method of Disposition	1401 20b. Place of Dis	Glen Avenue sposition (Name of		oury, MD				
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, ci	rematory or other place) cv of Delmar	va 08/22	/2006 De	lmar. DE	wii, olate		
21. Signature of Funeral Service Licensee		22. Name and Address of 705 E. Main				04		
Esqueritally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ras a consequence of):	ens win	1	PA PA	e	Approximate Interval Between Onset and Death		
in the past 12 months?	nt at time of death 5	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delive Month	ry Day Year		
Part II. Other significant conditions contributing to dea	th but not resulting in the	underlying cause given in	Part I.		use contribute to the			
				24a. Was an autopsy performed?	death?	osy findings available npletion of cause of 2 No		
25. Was case referred to medical examiner?			Place of Death (
1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Ing					6 ☐Other (Specify)		
2 Accident investigation 3 Suicide 6 Could not be	Injury Day Year) 28b. Time Injury Injury - At home, farm, s , etc. (Specify)	/ Work? M 1 ☐ Yes	2 🗆 No	d. Describe how in	and Number or Rura	Route Number,		
29a. Certifier (Check only) 1 ☐ Certifying Physician: To the base 2 ☐ Medical Examiner: On the base 2 ☐ M	est of my knowledge, dea is of examination and/or	ath occurred at the time, d investigation, in my opinio	ate and place, an	d due to the cause	(s) and manner as et	ated. the cause(s)		
29b. Signature and title of certifier	r stated.	29c. License nui			Date signed (Month, I			
	CIVIC AVE.	e, Print) , SALISBURY,	MD. 21	804	/			
31. Date filed (Month, Day, Year) 32. 32. 33. 33. 33. 33. 33. 33. 33. 33.	gistrar's Signature	hack !						

Stat Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 28142 1 - Stata Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death AUGUST 15, 2006 1856 GIOVANNI A. A. FACCHIANO 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death

Funera Director

Physician

/Medical

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

naral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

er	4a. Facility Name (4b. City, Town, or Location of Death 4c. Cou					ounty of De	ath					
	PRINCE GEORGES HOSPITAL CENTER					CHEVERLY				PRINCE GEORGE'S			
	5. Social Security N 579-46-83	Sex 7. A 1(∑) M 2□ F	ge (In yrs. I	ast birthday) Yrs.	If Under 1 Yea Months Days		er 24 Hrs. Min.	8. Date of Bir (Month, Da AUGUST	rth ay, Year) 7, 1935	9. B	inthplace (State or Fore Country) HINGTON, DC		
	Usual Residence of Decedent												
	10a. State	10b. County		10c. City, Town or Location							10d. Inside City Lim		
Director	MARYLAND PRINCE GEORGE'S HYATTSVILLE											1 ☐ Yes 2 🛛	
ire	10e. Street and Number						10f. Zip Code 10g. Citiz				n of What C	Country?	
	7419 25TH	AVENUE				2078:	3			Ţ	J.S.A.		
Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?				S. 13.	S. 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				No- 14. Race - American Indian, Black, White, etc.			
	1 Never Married 2 Marned 1 MYes 2 N							Specify:				inte, etc.	
d by	3 ☐ Widowed	4 ☐ Divorced	Year or Dates: KOREAN		N	To Tos Zigito Specily.			Specify: WHI			WHITE	
Completed	(Spec	15. Decedent's l				lea. Decedent's Usual Occupation (Give kind of work done during most of working)				16b. Kind of Business/Industry			
npi	Elementary/Seco			College (1-4or 5+)		life. DO NOT use retired)						OPPUL OF	
Ç	11				MAIL H	AIL HANDLER			U.S. POSTAL			SERVICE	
Be	17. Father's Name (First, Middle, Last)					18. Mother's Name (First, M				ddle, Maiden Sumame)			
P_	PHILLIP		FACCHIA	FACCHIANO			ANNA			VAGN	VAGNONI		
	19a. Informant's N	ame/Relationship	(Type, Print)		19b. Maili	ng Address (Stree	et and Num	iber or Rur	al Route Numb	er, City or T	own, State,	Zip Code)	
	NORA RITA	FACCHIANO	/WIFE		7419 2	5TH AVENU	E, HYA	[TSVIL]	LE, MARYL	AND 207	783		
	20a. Method of Dis		☐Removal from State			sition (Name of matory or other pe	ace)		Date	20c. Loca	tion - City o	or Town, State	
		5 ☐Other (Spec		VETERAN	S CEMETERY				CHELTE	CHELTENHAM, MARYLAND			
	21. Signature of Fu	neral Service Lic	ensee () /	•	22	Name and Add	ress of Fac	cility	HOME INC				
	1 (1m	anda	Kude	WICH	11	NES-RINAL 800 NEW H	AMPSHII	RE AVE	NUE, SILV	ER SPRI	ING, MA	RYLAND 20904	
	23a. Part1. Enter t	he disease, or co	polications that cause by one cause on each	d the death	n. Do not ent	er the mode of d	ring, such a	as cardiac	or respiratory a	ırrest,		Approximate Interval Between	
	Immediate Cause	(Final			OMETER DI	T MONADA D	TOPACE					Onset and Death	
	disease or condition resulting in death)	on .	a. CHRONIC On a			LMONARY D	LSEASE					ZIEARS	
			Due to (or a	s a consequ	zerice Or).								
er	Sequentially list co	nditions, nmediate	b. — Due to (or a	s a consequ	uence of):								
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
Exa	that initiated events c												
edic			d										
Physician/Medical	IF FEMALE: 23b. Was deceden	t oregnant	23c. If yes, outcom	e of pregna	ncy		23d				d. Date of d	Date of delivery	
ciar	in the past 12	months?	1 ☐ Live birth 4 ☐ Pregnant a							Month Day Year			
iysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)												
											contribute	to the cause of death?	
d by	APPONING ASSETS ANEXPOYEN						1			XYes 2 No 3 Probably 4 Unknown			
Completed									24- 145-		241 141		
μ	24a. Was an autopsy performed?									24b. Were autopsy findings available prior to completion of cause of death?			
Ö									1 ☐ Yes	2 X No	1 🗆 Ye		
Be	25. Was case referred to medical examiner? 26. Place of Death (Check only one)												
2	1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient :									Residence 6 Other (Specify)			
iuo						Time of Injury at Work?			28d. Describe how injury occurred				
ati	2 Accident investigation						M 1 Tes 2 No						
Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	d 28e. Place of it	28e. Place of Injury - At home, farm, street, factory, officibuilding, etc. (Specify)			ice 28f. Location (Street City or Town, Str				t and Number or Rural Route Number, tate)		
29a. Certifier (Check only one) 1 X Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as s 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated.											as stated. ue to the cause(s)		
Me	29b. Signature and the discertifier						29c. License number			29d. Date signed (Month, Day, Year)			
	Samman NT						D07075			AUGUST 17, 2006			
	V / V)			. 20		D379	15			AUGUS:	∠ و/⊥ ا	2006	

Registrar

JEFFREY P. INDRISANO, M.D., 10801 LOCKWOOD DRIVE #280, SILVER SPRING, MARYLAND 20901

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

AUG 21

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician Month Mary Rita Goodman 10:48 P M August 12, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14127 Castle Blvd., #103 Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 ☐ M 2 🔀 F Yrs. 167-36-4665 Director 60 Jan. 14, 1946 Pennsylvania Usual Residence of Decedent 10a, State Hygiene. sthar then "naturel", or itams 23a or 28a-f ahow ent, the Madical Exeminet must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14127 Castle Blvd., #103 20904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White If Yes, Give Year or Dates: Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) General Clerk Telecommunications other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be f h and Mental h and Mental Connel Richard Mary Conway 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Heelth ar
Important: If item 27 ia
any injury or other trau 14127 Castle Blvd., #103. Silver Spring, ND 20904 of Disposition (Name of Date 20c. Location - City or Town, State Richard Goodman/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State August 16, 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2006 Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis Addess Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Head & Neck Cancer 4 Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. physicien Physician/Medical as the attending IF FEMALE: nse n 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) ed by the detached P.O. 9 Unknown 9 Unknown sete hes been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 XYes 2 No 3 Probably 4 □Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No After this certificete funeral director, pag 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 TResidence 6 Other (Specify) ၉ 1 Yes 2 XNo 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury death. 1 Yes 2 No nours after death neral Director: / filled in by the fi 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 D18219 August 16, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Staal, M.D. 1221 Mercantile Lane, Largo, MD 20774 31. Date filed (Month, Day, Year) AUG 18 32 Aegistrar's Signature State 2006 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink

raig Michael Gou	1- R	For State	Certificate of	f Death	Reg	g No. 200	5 2814				
Physician/ Medical Examine	1	Decedent's Name (First, Middle,Last) Craig M.Gouker			2. Date of Death Month August 16,		3. Time of Death 1830 hrs				
grand, E		a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of De							
Funeral	5	10945 Boulevard Circle Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Owings Mills If Under 1 Year If Under 24	Hrs. 8. Date of Birth	n(MM/DD/YYYY) 9. Birt	hplace (State or				
Director	Ļ	160-48-8208 1 M 2 F 4	7 Yr		Nov.5	,1958 Foreig	n untry) Pa				
any	_		10c. City, Town or Loca	tion			10d Inside City Limits				
Maryland 28a-f show at at once.	اِ اِ	PA Adams De Street and Number	Hano	Ver	10	10g Citizen of What Country?					
		oe. Street and Number 515 Old westminster Ro	J	17331		USA	lu y '				
r death with th or items 23a must be notii	lera 1	1. Marital Status 12. Was Decedent E Armed Forces?	Ever in U.S. 13. W	as Decedent of Hispanic Origin? Yes, specify Cuban, Mexican, Pue			can Indian, Black,				
fter dea		Widowed 4 Divorced If Yes, Give Year or Dates:	No 1	Yes 2 No specify:		Specify:	white				
hours after "natural" Examine	o Dej	15. Decedent's Education (Specify only highest grade comp	during i	nt's Usual Occupation (Give kind nost of working life, DO NOT use	ation (Give kind of work done 16b. Kind of Business/Industry						
21215-0036 uld be filed within 72 hours after Mental Hygiene marked other than "natural"; event, the Medical Examiner.	uble u	Elementary/Secondary (0-12) College (1-4 or 5 12	· ·	pervisor		Constru	ction				
21215-0036 uld be filed within 7 Montal Hygiene marked other than event, the Medica	a	7. Father's Name (First, Middle, Last)	-		mme (First, Middle, M	laiden Surname)					
	n 0 1	Roger Gouker 9a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number	or Rurai Routė Numl						
nore, MD 21215-0 ages 1 and 2 should be file, w not of Health and Montal Hy git t: If item 27 is marked oth other traumar c event, the A TO Re CO	2	Roger Gouker-Father Oa. Method of Disposition	20b. Place of Dispo	O Glenwyn Dr.	<u>Little</u>	stown, PA1 20c. Location - City or	7340 Town, State				
Baltimore, oermit. Pages I ar Department of Hee Important: If ite	- 1	Burial 2 Cremation 3 Removal from Sta Donation 5 Other Specify:	crematory or o	ther place) 11 Crematory 8	1/21/06	Hampste	ad MD				
Baltimore permit. Pages I Department of F Important: If injury or other		Signature of Funeral Services Licensee	22.	Name and Address of Facility			17340				
Physician	2	3a Part I. Enter the disease, or complications that caused to	the death Do not enter	Little's FH 3 the mode of dying, such as cardia	4 Maple ac or respiratory arre	Ave.Litt st, shock, or heart	Approximate Interval				
Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause.									
in the state of th											
led nisit	Exa	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
e be executed sistence of burial - transit	Medical	UNPENDED AMENDED									
8760, ifficate be up physici	- D	F FEMALE: 3b Was decedent pregnant in the 23c. If yes, outcom		etal death 3 Ectopic pre	gnancy	23d. Date of delivery	/ Day Year				
Box 687 e death certific the attending ped for use as the	sician	past 12 months? 4 Pregnant at time of death 5 Other (Specify)									
O. Bo at the de d by the		Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause given in Part I.		bacco use contribute to					
ls, P.O. quires that the en signed by a lid be detached by a lide of the property of the prope	ed b	Hypertensive Atherosclerotic Cardiovascular Disease 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 124b. Were autopsy findings available									
cords,	Completed by	autopsy prior to completion of cause of performed? death?									
Vital Recysician: The libit certificate lidirector, page	မ္တို	25. Was case referred to medical	· · · · · · · · · · · · · · · · · · ·	26 Place of Death (Che		2 No 1 V	es 2 No				
of Vitaing Physici	의	examiner? 1 ✓ Yes 2 No Proposition 1 Inpatien 1 Mospital: 1 Inpatien 27. Manner of Death 28a. Date of Inju	rv 28b. Time o			Residence 6 Other	r: Scene				
OD O	ition.	1 Natural 5 Pending Aug 16, 2006	ear) 0000 hrs	1 ✓ Yes 2 No		tal asphyxia in ma	nhole				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the control of the physician and the control of the c	Certification:	3 Suicide 6 Could not be 28e, Place of Inj		eet, factory, office building, etc.	or Town, St						
Hospitz 24 hours Funera	မှု မှ	4 Homicide determined (Specify) Work Site 10945 Boulevard Circle, Owings Mills, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.									
To the within To the comple	훓ᆫ	Medical Examiner: On the basis of examiner and manner stated. 29b. Signature and title of certifier	mination and/or investig	ation, in my opinion, death occurr	ed at the time, date a						
12/22	2	ar of the	Dan	O.C.M.E.		29d Date signed (Month, Day, Year) August 17, 2006					
13 N	+	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
Sta	te	Carol Allan, MD Assistant Medical Exam 31. Date filed (Month, Day, Year) 32 Registral	niner 111 Penr r's Signature	i Street, Baitimore, MD 21	ZU1						
Registra	ar	AUG 2 2 2006 Steam	A for	who							
DHMH 17 Rev 1/200	01		ORIGIN	AL							

State of Maryland / Department of Health and Mental Hygiena 1 - For State Registra 28145 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 18 2006 Cynthia Kaye George 6:45 P M August /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3307 Carlisle Drive Knoxville Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 31, | 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖾 F 53 Director July 218-64-3144 Charles Town WV Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location 28a-f ehow 10d, Inside City Limits the Medical Examiner must be notified at Director 1 ☐Yes 2 No MD Frederick Knoxville 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? with ö 3307 Carlisle Drive 'natural', or itema 23a 21758 USA death Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or itemaging event any injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 🙀 No þ Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Clem Wilson Lora Jane Osborne ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John S. George, Husband 3307 Carlisle Drive, Knoxville, MD 21758 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 □ Doparion 5 □ Other (Specify) Resthaven Memorial Gardens 8/23/06 Frederick, MD 21. Sign was of Fulleral Service Licensee ^{22 Name and Address of Facility} John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD barbara A. Williams, 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ARREST disease or condition resulting in death) CARDIAC /Medical Due to (or as a consequence of) Examiner GORGNARY ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed CHRONIC OBSTRUCTION PLLNONARY DIEASE P.O. Box 68760. physician Physician/Medical DABETES MELLITUG use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy ŏ Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 □ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury ours after death. neral Director: All filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funeral Dire Hospital 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2. Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely the e 29b. Signature and title of continer 29c. License number 29d. Date signed (Month, Day, Year) 0101048461 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) 4415 MAIN ST. MICHAEL T. WENZEL RUBESLLYLLE VA. 31. Date filed (Month, Day, Year) AUG 2 2 32. Registrar's Signature State en & sport Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 28146 1 - For State Registrer 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 28 Day 2006 **Physician** Griffin 8:29 A.M Virginia /Medical 4a. Facility Name (I) not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3907 71 AVENUE LANDOVER HILLS MARYLAND PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB . 12,1911 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 🕱 F 230-09-5738 95 VIRGIŃIA Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?? is marked other then "natural", or Iteme 23a or 28a-f ahow treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🛣 No LANDOVER HILLS MARYLAND *Maryland* Directo PRINCE GEORGE"S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3907 71 AVENUE LANDOVER HILLS MARYLAND 20784 U.S.A.Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK þ 3 XWidowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be 1 Heelth and Mental I UNKNOWN HATTIE EVANS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 EDITH BROOKS (DAUGHTER 3907 71 AVENUE LANDOVER HILLS MARYLAND 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of Hi
Important: If iter
any Injury or oth 1 Burial 2 Cremation 3 Removal from State LYELLS CHAPEL CHURCH 8/31/2006 HAYNESVILLE VA. □ Donation 5 □ Other (Specify) 22. Name and Address of Facility BERRY O. WADDY P. O. BOX 305 21. Signature of Funeral Service Licensee 6784 MARY BALL ROAD LANCASTER VA. 22503 Approximate
Interval Between
Onset and Death
2 months 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** failule to thrive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner enile dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine be executed signed by the attending physicien and does detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by heart failure congestive 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No : After this certification at the state of t 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ol or Attending F after death. Certification: 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel o within 24 hours aft To the Funeral Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 022780 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7500 Green Way Ctr Dr. Green belt, MD 20770 Schistor 31. Date filed (Month, Day, Year) 32 pegistrar's Signature State SEP 0 6 2006 Registrar

	1	For State Registrar	State of I				of H	ealth a		ntal Hvo	iene	-	28147
Physiciar /Medica) 	1. Decedent's Name (First, Middle, I George Vincen 4a. Fecility Name (If not institution, g	t Gordon	ar)		4h City 1	Fown or	Location of	1	Date of Dea Month	+ 28	Year 2006 unty of Death	3. Time of Death P
Examine Funeral Director		Washington Count	y Hospita	1	last birthday)	Hag	erst		24 Hrs. 8. Min.	Date of Birth (Month, Day	Year)	ashing	ton place (State or Foreign ntry) PA
2		Usual Residence of Decedent 10a. State 10b. County MD. Washing	ton		ty, Town or Lo	cation				, , , , , , , , , , , , , , , , , , ,			10d. Inside City Limits 1 ሺ Yes 2 🗆 No
iteme 23	2	10e. Street and Number 4 Fulton Stre 11. Marital Status 1 Never Married 2 Married	et 12. Was Decede Armed Force	ent Ever in U			2175		jin? (Specif , Puerto Ric	y Yes or No- an, etc.)	USA	of What Cou Race - Ameri Black, White	can Indian,
15-003 n 72 hours n "natural", ladical Exa	Completed by r	3 Widowed 4 Divorced 15. Decedent's (Specify only highest: Elementary/Secondary (0-12)	If Yes, Give Year or Date Education grade completed)	es:	16a, Dece	dent's Usua kind of wor DO NOT us	I Occupa	ation	of working			ecify: Wh: of Business/In	ite
and 212 d be filed withi ental Hygiene. ced other ther cevent, the M	100 ag 01	17. Father's Name (First, Middle, La	College (1-4	or 5+)	Paint	er			rs Name (F	irst, Middle,		Contra mame)	actor
	-	19a. Informant's Name/Relationship Vincent S. Gordo 20a. Method of Disposition		20b. F	116 W	ashin	gtor	nd Number	r or Rural R	ncock	MD 21	own, State, Zij 250 ion - City or To	
Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or othe		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lij	cify)	ate		rg Cre	emato d Addres	ory 08	У	141 W	est M	sburg, ain St	reet
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76(ical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Se Due to (or c. Re	r as a consecutive for a consecutive fo	quence of): quence of): Face	ure							1 W
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Cords, P.O. w requires that the been signed by the should be detache	ted by Pn	Part II. Other significant condition	s contributing to dea	th but not res	sulting in the u	nderlying ca	ause give	en in Part I.			bacco use		the cause of death?
of Vital Reconviction: The law in this certificate has be I director, page 2 sh		25. Was case referred to medical						26 Place	of Death ((24a. Was a autop perfor 1 ☐ Yes	sy med? 2 No		opsy findings available ompletion of cause of 2 No
Division of Vital Records, To the Hospital or Attending Physicien: The law requires t within 24 hours effer death. To the Funstel Director: After this certificate has been signs completely filled in by the funeral director, page 2 should be	Medical Certification: 10 be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no determin	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	M 2	8c. Injun Work 1 🔲	er: 4 □ Nur	rsing Home 280	5 □ Resid	ence 6 ow injury o		ral Route Number.
Hoepital o 24 hours eff a Funerel Di etely filled in	dical Ce	29a. Certifier 1 Certifying (Check only one)	Physician: To the basaminer: On the basand manne	is of examina	owledge, deal ation and/or in	h occurred avestigation,	at the tin	ne, date and pinion, deat	d place, and th occurred	d due to the o	ause(s) and pla	d manner as ace, and due	stated. to the cause(s)
To the within 2 To the complex	Me	29b. Signature and title of certifier		of dooth (to	222) (T			23 Z	23			igned (Month)	, Dey, Year)
Stat Registra		30. Name and address of person w 31. Date filed (Month, Day, Year) SEP 0 6	n 112	istrar's Sign	pal	Con	nt	1+	9. 1	nd i	174	U	

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Edwin Elmer Henry 17, 2006 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CENTER REGIONAL Nicomico 54018bU1 KENINSULA MOKOK If Under 1 Year | If Under 24 Hrs. | 6. Sex 14 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Yea 6-23-1932 Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 221-22-3851 Yrs. Director Delaware Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if Itam 27 is marked other than "natural", or Iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be martified an once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director De. Sussex Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6260 Sharptown Road 19956 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊉Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Dupont Co./Nylon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur E. Henry Berta Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Henry (Wife) 6260 Sharptown Road Laurel, De. 19956 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Mt. Pleasant Cem. Aug.21,2006 Laurel, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hannigan, Short, Disharoon Funeral Home Inc. 21. Signature of Funeral Service Licenses Holly Short during are 1700 West Street Laurel, De.

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 700 West Street Laurel, De. 19956 Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed is certificate has been signed by the attending physicien and director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 No 3 Probably 1 🗌 Yes 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No М investigation 2 Accident within 24 hours after death To the Funarei Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 8-17-2006 D54127 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pocuer (00) mn Davis 31. Date filed (Month, Day, Year) 32. Poistrar's Signature State AUG 22 2006 Registrar

			1 - For State Registrar		State of Ma	aryland	d / Depa <i>Cer</i>	rtment of F	lealth and Death	Mental F	lygien Reg. N	200	6	28149
	Physici	an	1. Decedent's Name		•		3			2. Date of Month		ay Ye	ar	3. Time of Death
	/Medic	al	Hazel		inia street and number)	ном	ward	4b. City, Town, o	r Location of De	Augu		20 20 lc. County of E	0 6	12:35P ^M
	Examin	er		ad Morgan				Lothia			1	Anne A		lel
	Funeral		5. Social Security No	umber 6. Se	7. Ag	e (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 H		Birth Day, Yea	9.	Birthpla	ce (State or Foreign
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	tems	Funeral	11. Marital Status		12. Was Decedent Armed Forces?		S. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? an, Mexican, Pue	(Specify Yes or erto Rican, etc.)	No-	14. Race - A Black, V	Americar Vhite, et	
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ָט כ			20a. Method of Disp		Removal from State	20b. Pla	ace of Dispos	sition (Name of natory or other place	(e)	Date	20c.	Location - City	or Tow	n, State
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۲	A)	16 T	23a. Part1. Enter the shock, or hear	ne disease, or comp rt failure. List only o	lications that caused one cause on each li	the death	. Do not ente	er the mode of dyin	g, such as cardi	ac or respiratory	arrest,		le le	pproximate nterval Between
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2	or Atti	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injubulding, et	ury - At hor c. (Specify,	me, farm, stre	et, factory, office			(Street a Town, Sta		r Rural F	Route Number,
2	pitel ours al		29a, Certifier	12 Cartifying Phy	ysician: To the best	of my know	uladaa daath	accurred at the tir	no data and ala	oo and due to ti		(a) and mann		
	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only one)	2 Medical Exem	iner: On the basis of and manner sta	examinati	ion and/or inv	estigation, in my o	pinion, death oc	curred at the tim	e, date a	nd place, and	due to th	ne cause(s)
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State of Maryland / Department of Health and Mental Hygiene For State Registrat 006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Darlene Holland 6:15 P M Aug 17, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick Calvert Calvert County Nursing Center If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 X F 577-86-4203 Yrs. 54 Director Aug 21, 1951 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural," or items 23a or 28a-f ehow eny injury or other traumatic event. The Medical Event. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 Yes 2 No Prince Frederick MD Calvert Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20678 U.S.A. 355 Radio Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black ۶ ک 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None **Never Worked** 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Beatrice Green Wilmer Holland 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sylvia I. Booth/sister P.O. Box 914 Prince Frederick, MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/23/06 Huntingtown, MD Patuxent UM Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Sewell Funeral Home Haden Jewes 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final wa **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Year in the past 12 months2 1 ☐ Yes 2 ☐ NO Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 9 2 ☐No 3 ☐ Probably 4 🗍 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? this certificate or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 →No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 25475 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) Prince Frederick MD 20678 ukesh 32. Registras Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

State of Maryland / Department of Health and Mental Hygien 2006 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) AUGUST 17, Day 2006 Year **Physician** 4:05 A M HOLTZMAN STEPHEN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MONTGOMERY POTOMAC 7820 Mary Cassatt Drive If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Aug • 1 , 9. Birthplace (State or Foreign Country)
Wash. D. C. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Days 1 💢 M 2 🗆 F 63 Yrs Aug. 217-42-1313 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show Itam 27 is markad othar than "natural", or Items 23a or 28a-f shov othar traumatic evant, the Medical Examinar must be notified at 1 X Yes 2 □ No Potomac Maryland Montgomery Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 7820 Mary Cassatt Drive U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after all Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Itimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Insurance Insurance Broker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H Be Elsie Loube Max Holtzman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is any injury or othar tra once. 7820 Mary Cassatt Drive, Potomac, Maryland 20854 Susan H. Holtzman - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tXI Burial 2 ☐ Cremation 3 ☐ Removal from State King David Mem. Gdns | 8/20/2006 Falls Church, Virginia `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland 21. Signature of Funeral Service License Donald Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each like. Immediate Cause (Final **Physician** Lymphoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) requires that the death certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death signed by the at id be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown 1 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law autopsy performed 2X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Yes 2X No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 531777 August 17, 2006 30. Name an Landress of person into completed cause of death (Item 23a) (Type, Print) 9707 Medical Center Drive, Suite 300, Rockville, MD. Dr. John M. Wallmark 31. Date filed (Month, Day, Year) State 21 AUG Registrar

State of Maryland / Department of Health and Mental Hygiene [0] 28152 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death HODG-SON Month **Physician** 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY HOSPITAL MONTGOM 68 If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) State or Foreign **Funeral X**XM 2□ F Months Days Hours Min. Yrs. 86 331-07-9687 Director July 13, 1920 ILUsual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryla Department of Health and Mental Hygiene.
Department of Health and Mental Hygiene.
Inportant: if Item 27 is marked other then "natural", or Iteme 23a or 28e-f show may injury or other traumatic event. Ite Medical Event net must be notified at once. 1 ☐ Yes 2X No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 15201 Elkridge Way, #3A USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates 1942-45 † ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Special Assistant Postmaster General 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Matthew Hodgson Lelia Berryman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary B. Hodgson / wife 15201 Elkridge Way #3A, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20, 2006 Alexandria, VA Metropolitan Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. (dlus 500 University Blvd. West, Silver Spring, MD 20901 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRITORY Physician disease or condition resulting in death) /Medical Examiner UNG CAN COR YRS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? Records, ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 X No 1 Tes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 1 ☐ Yes 2 ☑ No 2 ER/Oulpatient 3 DOA To the Hospitel or Attending Pt within 24 hours after death. To the Funerel Director: Atter th completely filled in by the funeral 28c. injury at Work? 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Lyaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) AVE #575 WHOATON MD 20902

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** EDNA VIRGINIA HARPER 19, August 2006 03:30 p^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Gaithersburg Montgomery Wilson Health Care Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, Year) June 15, 1910 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F 578-58-1184 96 Yrs. Virginia Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ai Hygiene. I other then "natural", or items 23s or 28s-f ehow vent, the Medical Examiner must be multisquat 1X Yes 2 □ No Director Gaithersburg Md. Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 403 Russell Ave. **#510** 20877 United States permit. Pages 1 and 2 should be filed within 72 hours after death \times Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 236 any july or other traumatic event, the Wedical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Statistical Supervisor Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sallie Elizabeth Cook William Henry Props 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mt. Solon, Va. 22843 Elizabeth C. Selkirk (Niece) 3611 Scenic Hwy. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State Aug. 20, Metropolitan Crem. Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) 2006 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cerebrouzscular disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.) Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed b Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 2□ No 1 Yes 1 Yes the Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☑ No 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending death. 1 Tyes 2 No after death Director: / 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Madical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Tot 29b. Signature and title of certifier 29c. License number 3 30. Name and address of a son who completed cause of death (Hem 23a) (Type 'Ave, baithersburg Russel 31. Date filed (Month, Day, Year) 32 Registrar's Signature 2006 21 Registrar

		1	For Stata Registrar	State of Maryland		nent of Health and cate of Death		giene 006	28154
	Physicia /Medic			anor Ha	iskins		2. Date of Dea Month Aygus	+ 20, 2000	
	Examin	er	4a. Facility Name of not institution, give	street and number)	~	City, Town, or Location of Di Eastor)	4c. County of Deal	+
H	Funeral Director		005-16-88911	7. Age (In yrs. I		Inder 1 Year If Under 24 Hours N	Ain. 8. Date of Birtle (Month, Day	h y, Year) 9. Bird Co	hplace (State or Foreign buntry) aryland
	laryland show	or	Usual Residence of Decedent 10a. State 10b. County		, Town or Location		/		10d. Inside City Limits
	or 28a-f	Direct	MD Talbo		10	f. Zip Code		10g. Citizen of What Co	ountry?
	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23e or 28a-f show other traumetic event, the Madical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	Road S. 13. Was I	Decedent of Hispanic Origin's, specify Cuban, Mexican, Pt	(Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, Whit	
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and 2	be filed within ital Hygiene. Id other than event, it a Mar	Be	17. Father's Name (First, Middle, Last))) ,		1	Name (First, Middle,		elses nome
Maryland	should and Mer s marke umetic	To	19a. Informant's Na Relationship (T)		19b. Mailing Ad	dress (Street and Number of		or, City or Town, State, 2	Zip Code)
	s 1 and 2 f Health a item 27 ls		20a. Method of Disposition		7049 A lace of Disposition emetery, cremator	(Name of	CK Road	Laston - Civor	MD, 2/60/ Town, State
altimore,	t. Page rtment c rtent; If		1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	Ye	-01001015	Connetence 8	125/06	Hurlock,	Maryland
Ba	permi Depa Impo any ir	g g	▶ Janelle C	. Henry	510	ne and Address of Facility RY FUNERA Washington	NSTICAN	bridge, IV	10,2/6/3
	Physician		23a. Part1. Enter the disease, or comp. shock, or heart failure. List only o Immediate Cause (Final disease or condition	ications that caused the death	Faclus		diac or respiratory ar	rest, J/	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions	1	uence of):				10 day
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence)	uence of):				20 dgs
8760,	death certificate be executed e attending physician and ad for use as the burial-transit		resulting in death) Last	Due to (or as a consequent	uence of):				
Вох 68	aath certifica attending ph for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal		pic pregnancy		23d. Date of del	ivery
P.O. B	res that the death signed by the atte l be detached for	hysicia	in the past 12 months? 1 ☐ Yes 2 ☑/No 9 ☐ Unknown	4 Pregnant at time of de		ar (specify)		Month	Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions co	ntributing to death but not resu Head Fail Scan.	ulting in the underh	ring cause given in Part I.		obacco use contribute to 'es 2 □ No 3 □ Pr	o the cause of death? obably 4 Dunknown
Division of Vital Records,	9 4 9	Completed	Hyperten.	sion.				rmed? prior to death?	utopsy findings available completion of cause of
/ital	icien: Th certificate rector, pag	Be Co	25. Was case referred to medical examiner?			0.1	Death (Check only o	ne)	2 1 No
of	y Physicien: er this certific eral director,	n; To	27. Manner of Death	28a. Date of Injury	28b. Time of	DOA Other: 4 12 Nursin		dence 6 Other (Spenow injury occurred	cify)
rision	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director.	ertification;	1 Action 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Place of Injury - At ho	Injury Nome, farm, street, f	I 1 ☐ Yes 2 ☐ No		Street and Number or Ri	ural Route Number,
ă	the Mospitel or A hin 24 hours after the Funeral Dire npletely filled in by	O	4 Homicide	building, etc. (Specify			City or Tow		
	To the Hospitel within 24 hours a To the Funeral completely filled	edical	(Check only 2 Madical Exami	sician: To the best of my known nar: On the basis of examinat and manner stated.	ion and/or investig	ation, in my opinion, death of	ccurred at the time	date and place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. License number H 42587	,	29d. Date signed (Mont.	h, Day, Year)
,			30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, Print)	d & Eas	ton m b	21601	
	Sta Registr	ite ar	29b. Signature and title of certifier MASL ² 30. Name and address of person who con the state of the state	32. Register's Signal	ture J	book			

Please Type or Print in Black Indelible Ink

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Charles Joseph Hamilton	State of Maryland / Department of Health and Mental Hygiene
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		Registrar	Centitio	cate of i	Death				g No.	JUb	2013
Physicia ledical Examir	n/ ner	Decedent's Name (First, Middle, Last) Charles Joseph H	amilto				م	Date of Death Month \ugust 30,	Day Year 2006	11	ne of Death
		4a. Facility Name (if not institution, give street and number) 11996 Lucey Rpad			. City, Town, Thurmont	or Location o	of Death		4c. County o		
Funeral			(In yrs. last b	irthday)	If Under 1 You	ear If Unde	1.10		(MM/DD/YYYY)	Foreign	· ·
Director		219-78-7883 1×M 2 F	46	Yrs.	MOTOTO DE	110015	(vail)	Nov. 5	1959	Country)	Maryland
any		Usual Residence of Decedent 10a. State 10b. County 1	0c. City, Tow	n or Locatio	n		_		20.		nside City Limits
Aaryland 28a-f show	ō	Maryland Frederick				rmont		1.0	011		Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once	Director	100. Street and Number			10f. Zip Code	2178	32	10	g. Citizen of Wh.	S.A.	
with the ns 23a of notif		11 996 Lucey Road 11. Marital Status 12. Was Decedent E	ver in U.S.		Decedent of h	lispanic Drig	gin? (Specif		14. Race	- American Inc	dian, Black,
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irs after ural",	<u>a</u>	3 Widowed 4 N Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade company)	oleted) 16a	a. Decedent's	Yes 2 X 1 s Usual Occup	ation (Give I	kind of work		Specify: 16b. Kind of Bus	White siness/Industry	,
5 72 hou in "nat	leted	Elementary/Secondary (0-12) College (1-4 or 5-		during mos	st of working I	fe. DO N DT	use retired))			
15-0036 Tied within 72 hours a Hygiene d other than "natural the Medical Examin, the Medical Examin	dmo	10 17. Father's Name (First, Middle, Last)		car	penter	18.Mother	's Name (Fi	rst. Middle. M	home	improv	ement
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, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once		19a. Informant's Name/Relationship (Type, Print) Gene M. Hamilton/ father	1		Address (Str				per, City or Town		ode)
and and fealt fealt tran	ŀ	20a. Method of Disposition		e of Disposit	ion (Name of			ate	20c. Location -		State
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Baltimore, permit Pages I ar Department of He Important: If ite	İ	Ignature of Funeral Service Licensee	2						uneral		
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/Medical Examiner	H	failure. List only one cause on each line. Immediate Cause (Final disease a. Acute corol.	ary thro	ombosis	due to	atheros	clerot:	ic cardi	.ovascular	1.	ween Onset and Death
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Box 68 e death certi the attendin ed for use as		past 12 months?	ime of death		er (Specify)		o programo,			,	
P.O. Box 6 that the death cer gred by the attendia	Physici	Part II. Other significant conditions contributing to death	but not result	ting in the ur	nderlying caus	e given in Pa	art I.	23e. Did tol	pacco use contri	bute to the cau	use of death?
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ords, w requir	Completed							24a. Was a autops perform	sy p		findings available tion of cause of
Rec The la					20 DI	ice of Death	(Chask anl	1 Yes 2		✓ Yes	2 No
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been shed in by the funeral director, page 2 should 1	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatier	nt 2 ER	/Outpatient		Other ₄	Nursing H		Residence 6	Other: Scene	e
ion of Verding Ph.	\vdash 1	27. Manner of Death 28a. Date of Injur (Month, Day, Ye		b. Time of In	jury 28c. I	njury at Work	- I	d Describe h	ow injury occurre	ed	
Sior Attend r death. ector: by the	catic	2 Accident Investigation 28e Place of Injury	ury - At home	farm street	factory offic	Yes 2	-	of, Location (S	treet and Numbe	er or Rural Rou	ute Number, City
Divisipital or At ours after deral Direct filled in by	Certification:	3 Suicide 6 Could not be determined (Specify)	ary 7 criomo	, raini, si ss	, , , , , , , , , , , , , , , , , , , ,		l _a	or Town, St			,
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical C	29a Certifier (Check only one) 2 Medical Examiner: On the best of my	knowledge, on	death occurr or investigati	ed at the time on, in my opin	date and pla on, death or	ace, and du ccurred at th	e to the cause ne time, date a	e(s) and manner and place, and d	as started ue to the caus	e(s)
or With	Me	29b. Signature and title of certifier				nse number		-	29d. Date signe		ıy, Year)
MJ		Hamet Fouthalf, ms			0.0	C.M.E,			August 31,	2006	
U		30. Name and address of person with completed cause of de Pamela Southall, MD Assistant Medical			enn Street	Baltimor	re, MD 21	1201			
St Regist	ate	31 Date filed (Month, Day, Year) 32. Rejistrar	's Signature	1							
DHMH 17 Rev 1/2		0 T 0 T C000 1		RIGINAL							

			1 - For State Registrar		State of	Marylar	nd / Depa	artmen rtificat	t of H e of L	ealth a Death	and Me	ntal Hy	giene Reg. No.	2006	5	28	156
ı	Physici	an	Decedent's Name (First HELEN) HOFFMAN						2	Date of De Month	ath Pay	Yea		3. Time o	of Death
	/Medio Examir		4a. Facility Name (If not in			oer)		4b. City,	Town, or	Location o	of Death	myus	/ / 6 4c.	County of D	6 leath	16,	/7 "
	E Adiiiii		371 LEWIS	/ILLE RI	D			Е	LKTO	N			(CECIL			
	Funeral Director		5. Social Security Numbe 233-50-2142	1	7]M 2]K]F	Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	Date of Bir (Month, Da ARCH 1	y, Year)		Country	ce (State y) IR, W	or Foreign V
	land ow		Usual Residence of Dece 10a, State 10b.	County		10c. Ci	ty, Town or Lo	cation							10d	d. Inside C	City Limits
	Mary B-f eh	tor	MD	CECIL			ELKTO:	N								1 🗆 Yes	2 ∑ No
	or 28	Director	10e, Street and Number			•		10f. Zip					•	zen of What	Country	y?	
	s 23e		371 LEWIS		D 12. Was Deced	ont Euros in III	15 12	Man Dage	219		sin? (Casail	. Van as Na		SA 14. Race - A		- Indian	
980	72 hours after death with the Maryland naturel', or Items 23a or 28a-f ehow diesi Exeminar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 3 ☑ Widowed 4 ☐ □	2 Married	Armed Ford 1 Tes 2 If Yes, Give Year or Date	es? ⊠No		f Yes, spec			n, Puerto Rio	y Yes or No an, etc.)		Black, W		C.	
2-0	72	Completed	15, E (Specify on	Decedent's Edu	cation e completed)		16a. Dece	kind of wo	rk done d	urina most	t of working		16b. Ki	nd of Busine	ss/Indu	stry	
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Maryland 21215-0036		ToB	WILLIAM	T	SMITH					RUT	TH		OVE	RBAY			
/au	2 sh and ie m		19a. Informant's Name/P				1	-					-	r Town, State	э, Zip Ci	ode)	
	1 an Heal		ROBERT J. S		FMAN,	SON 20b. F	Place of Dispo	sition (Nan	ne of	LE RD) ELK Date	TON, I		21921 cation - City	or Town	n State	
nor			1 Burial 2 Cre 4 Donation 5 0		lemoval from St		cemetery, crer ZERDALE	natory or o	ther place					WARK,		i, otato	
Baltimore,	글북달글 .		21. Signature of Funeral			FIA I				s of Facility				IN FUN		I. HON	MES INC
œ _	Depa Impo any i		tional	Man	14	4.					WY NEV	VCASTL	E, D	E 1972			
	Physician /Medical		23a. Part1. Enter the dis shock, or heart failu Immediate Cause (Final disease or condition resulting in death)	∍ase, or compline. List only or	e cause on each	sed the deat th line.	Can	er the mod	e of dying	g, such as	cardiac or re	espiratory a	rrest,		1r	Approxima Interval Be Onset and	tween
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<u>,</u>	cate be executed physician and the burial-transit	Exan	that initiated events resulting in death) Last	٥		as a consec	quence of):								+		
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89)	artifica ing ph e as th	Med	IF FEMALE:										-				
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<u>α</u>	s that the ned by a detac	by Ph	Part II. Other significant	conditions cor	ntributing to dea	th but not res	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did to	obacco u	se contribute	to the	cause of	death?
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ecc	as b	ompieted										24a. Was		24b. Were	autops:	y findings detion of o	available
E E		Con										perfo 1 ☐ Yes	rmed? 241 No	death 1 🗆 Y	?	□No	
Vit	Physician; 'this certifica	Be c	25. Was case referred to examiner?		lospital:		150.0		Othe			Check only o		200.50		710	
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io	투교통교	atio	2 Accident	Pending investigation	(MONIN,	Day Year)	Injury	м		es 2 □ N	No						
Division	P # 5 =	Certification:	4 ☐ Homicide	Could not be determined	building	, etc. (Specif						City or Tov	vn, State,				nber,
	To the Hospital within 24 hours a To the Funerel Completely filled	edicai	29a. Certifier 1 (Check only one)	ertifying Phys ledical Examir	sician: To the b ner: On the bas	is of examina	owledge, death ation and/or inv	occurred restigation,	at the tim in my op	e, date and inion, deat	d place, and th occurred	due to the at the time,	cause(s) date and	and manner place, and d	as state	ed. re cause(:	s)
	ithin 2 o the	Mec		f certifier	and manne	r stated.		290	License	number			29d. Date	e signed (Mo	onth, Da	y, Year)	
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	¥ .		30. Name and ddress of	person who co	mpleted cause	of death (Iter	п 23a) (Туре,	Print)		. /	+				1		2
	6		H Farka	3,1	P	Seaso.	ns fog	pice	, 1	E/K	lon,	1)				
	Sta Registr		31. Date filed (Month, A	JG 2 2 2	.006 ^{32. R}	istrar's Signa	atures A	paste									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006

				,	Cei	rtificate	e of Death	Re	g. No.	
			1. Decedent's Name (First, Middle, Lest,)	11			2. Date of Death Month	Dey Year	3. Time of Death
	Physicia		Fannie Eliza	beth Her	shberg	ger		August	27,2000	2:00 PM
	/Medic Examin		4a. Fecility Name (If not institution, give		Home			ville	Garr	ett
	Funeral Director		103 30 0030	7. Age (In y	rs. last birthday) Yrs.	If Under Months	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, 08-01-19	9. B 906 AR'	rthplace (State or Foreign Country) LHUR, IL
busine	-f show fled at	tor	Usual Residence of Decedent 10a. State 10b. County MD GARRETT		City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
dt the	3e or 28e at be nut	al Director	10e. Street and Number			10f. Zip			g. Citizen of What C	Country?
UZU	Mental Hygiene. Advantal Hygiene. Advantal Hygiene. Attend other than "netural", or items 23e or 28e-f show after event, the Mydical Examiner must be nutified at	by Funeral		12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2√ No If Yes, Give Year or Dates:		Was Deced If Yes, spec 1 ☐ Yes 2	ent of Hispanic Origin? (S ify Cuban, Mexican, Puert X No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh Specify: W	ite, etc.
2-0-12 2-0-12 2-13-14 2-15-14 3-14-14	n "netura Madical I	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed) College (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us	Il Occupation ik done during most of wor ee retired)		6b. Kind of Busines	s/Industry
Maryland 21215-0020	Hygiene other tha /ent, the	Be Com	17. Father's Name (First, Middle, Last)		HOUS	EWIFE		ne (First, Middle, M	OOMESTIC laiden Surname)	
Tylai	and Mental Hygie is marked other t raumatic event, to	TO E	FRED , MALICOTE 19a. Informant's Name/Relationship (7)		19b. Mail	ing Address	TILLIE (Street and Number or Ru		City or Town, State	, Zip Code)
ore, Ma	-		ANNA MARIE BEACH 20a. Method of Disposition 1 Burial 2 Tycremation 3 G	Y 20 Removal from State	 b. Place of Disposered cemetery, cre 	osition (Nan matory or o	ther place)	JONESBO Date 2 8-29-200	0c. Location - City	01 or Town, State TOWN WV 26506
baitimore,	perimit. Frages Fail Department of Heat Important: If item 2 any injury or other once.		4 ☑ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens		/ 1	2. Name an	d Address of Facility MAN GIFT REC	GISTRY	0 HORGAN	
			23a. Part1. Enter the disease, or comp shock, or heart failure. Ist only of	dications that caused the done cause on each line.	leath. Do not en	10 RGAN iter the mod	TOWN WV 2650 e of dying, such as cardia	or respiratory arre	st,	Approximate Interval Between Onset and Death
	hysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	aDue t	to (or as a conse		the re	ctum		lyear
'n	executed an and rial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due t	to (or as a conse	equence of):				
X 68/6U,	earn cernicate be executed attending physician and I for use as the burial-transit	Medical	Cause (Disease or injury that initiated events resulting in death) Last	d.	o (or as a conse	quence of):				
0	atten atten 3 for u	ciar	Part II. Other significent conditions co	ontributing to death but not	resulting in the	underlying	ause given in Part I.	23b. Did to	becco use contribu	ite to the ceuse of death?
о. О.	es that the death or igned by the attend be detached for us	Physician	nohe	THIRDUING to death out not	Tooding III III	u		1 □ Ye	es 2 No 3□	Probably 4 Unknown
of Vital Records,	been s	leted by						24a. Was a perform		b. Were autopsy findings available prior to completion of cause of death?
E Ke	Ine lav ate has page 2	Completed						1 □ Ye	s 2 No	1 ☐ Yes 2 ☐ No
159	ysicien: The s certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other:	ath (Check only on		
on of	ing Phys After this funeral di	ion: To	27. Manner of Death 1 Delatural 5 Pending	1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	28b. Time		DA Street 4 Nursing 1 28c. Injury at Work? 1 ☐ Yes 2 ☐ No		ence 6 ⊡Other (S ow injury occurred	pecify)
Division	I or Attending after death. Director: After d in by the fune	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		At home, farm, s pe <i>cify)</i>			28f. Location (St City or Town	reet and Number or n, State)	Rural Route Number,
	Hospita 24 hours Funerel tely filler	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysicien: To the best of my niner: On the basis of exar and manner stated.	knowledge, dea mination and/or i	th occurred investigation	at the time, date and plac n, in my opinion, death occ	e, and due to the caurred at the time, d	ause(s) and manner ate and place, and	as stated. due to the cause(s)
	To the Hospital or Atte within 24 hours after de . To the Funerel Directo completely filled in by the	Med			M	29	c. License number	2	9d. Date signed (M	onth, Day, Year)
			30. Name and address of person who walker K. 31. Date filed (Month, Day, Year)	Completed cause of death	(Item 23a) (Type	e, Print)	100 L) 1)	7	hing ust	1520
7	1 0		Walter K. N 31. Date filed (Month, Day, Year)	aumanh.	MI) Signature	10 B	ex 241, /te	cident	- MD 2	LIJEU
	St	ate	CED 0 6 2	DOG Maria	1 1 1	See L	,			

DHMH 16 Rev 6/95

32. Registrar's Signature

ORIGINAL

0 6 2006

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygien 2006 28159 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Gertrude C. Jones 0200 Aug 17, 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2X F Yrs Director 220-26-6924 79 Jan 12, 1927 Maryland Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County in than "natural", or itams 23a or 28a-f show 1 ☐ Yes 2 X No Huntingtown Director MD Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20639 U.S.A. 78 Sheckles Road death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or its rry or other traumatic event, it a Medical Examina 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Restaurant Cook 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Rose Jones Thomas G. Ray မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 155 MacArthur Drive Huntingtown, MD 20639 MacArthur Jones/nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition > Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o important: if any injury or once. 08/22/06 Chesapeake Beach, MD St. Edmonds UMC Cemetery A □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Sewell Funeral Home Kady 1451 Dares Beach Road Prince Frederick, MD 20678 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final J Physician 47 U/ 10.0 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury Examine attending physician and for use as the burial-transit The taw requires that the death certificate be executed that initiated events resulting in death) Last o (or s consequence of): Division of Vital Records, P.O. Box 68760 an/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death Physicia 5 Other (specify) 1 Yes 2 No detached signed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ briknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 700 24a Wasan autopsy performed? has certificate 1 ☐ Yes 2 - NO or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 PER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Injury 5 Pending 1 🗌 Yes 2 No death. investigation 2 Accident after death filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funerel L 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of ceptills 29c. License number δ 10061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick, MD. 20678 Math Rond Hospital 110 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State AUG 1 8 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200628160 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vaar **Physician** Raymond Lorenzo Johnson August 14, 2006 8:45P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver FUnder 1 Year Ionths Days Fox Chase Nursing Home Montgomery Spring Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1**⊠**M 2□ F Months Hours 76 Yrs. Director 577-40-9963 June 25,1930 Wash., DC Usual Residence of Decedent the Maryland 10c. City Town or Location 10d. Inside City Limits 10b County 10a State 28a-f show Examiner must be notified at 1 ☑ Yes 2 ☐ No Directo Silver Spring Md. Montgomery 10c. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 23a 2015 East West Highway 20910 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🙀 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Black natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer Private 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Deportment of Health and Mental Hy Important: if them 27 is marked oth any injury or other traumatic event 2008. Be George Johnson Sarah Worthy ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Covella Peterson/granddaughter 27 D St., SE, Washington, DC 20003 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) Resurrection Cem. 8/21/06 Clinton, Md. 22/Name and Address of Facility Hodges & Edwards F.H. Aign ture of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, MD. 20746 yart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Is mediate Cause (Final disease or condition resulting in death) **Physician** Acute Coronary Syndrome Instant /Medical Due to (or as a consequence of): Examiner 6 Months Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed ding physicien and resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Dementia 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No Dilated Cardiomyopathy 24a. Was an certificate 1 Yes 2 X No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 M Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No Certification; To this After this funeral of 28c. Injury at Work? 28a. Oate of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending s after de-1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifie 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State **Registrar**

8609 Second Ave.,

32. Registrar's Signature

A COURT

30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Print)

Dr. Ravi Passi,

31. Date filed (Months Da

D28656

August 15, 2006

Silver Spring, MD 20910 #404B

			1 - For State RegistraMEND#17perFH8/1	State of Marylar 8/06,BMW,McCo	nd / Depa <i>Cer</i>	artment <i>tificate</i>	of Hea of De	Ith and Math	He	g. No.	06 28161
	Physicia	_	1. Decedent's Name (First, Middle, Last) Gertrude	KLEIN					2. Date of Death Month Aug. 16		3. Time of Death 2:15 A. M
Ē	/Medic Examin	_	4a. Facility Name (If not institution, give s Shady Grove Advent				Town, or Loc ville	ation of Death		4c. County of Montgom	
	Funeral Director		5. Social Security Number 6. Sex 113-03-2849		last birthday) Yrs.	If Under Months		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthplace (State or Foreign Country) Russia
	aryland show	_	Usual Residence of Decedent 10a. State 10b. County MD Montgomer		ty, Town or Lo						10d. thside City Limits 1 1 Yes 2 □ No
	or 28a-f	Director	10e. Street and Number			10f. Zip	Code 0877		10	g. Citizen of Wh	
36	rs after death w I', or items 23s	by Funeral	3 Sanders Cou 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	'	Was Deced	ent of Hispar ify Cuban, M	nic Origin? (Spe lexican, Puerto pecify:	ecify Yes or No- Rican, etc.)	14. Race Black	- American tndian, , White, etc. White
1215-00	within 72 hou ane. then "natura in Medical E	Completed I	Specify only highest grade (Specify only highest grade Elementary/Secondary (0-12) 12	cation	16a. Deced (Give life. I	kind of wor DO NOT us	l Occupation k done durin e retired)	n ng most of worki	ing	6b. Kind of Bus	
land 2	id be filed v ental Hygie ked other I	To Be Co	17. Father's Name (First, Middle, Last)	otin	2001111		18.		(First, Middle, Moskowi)
Mary	nd 2 shou lith and M 27 le mar r traumat		19a. Informant's Name/Relationship (Ty) Gloria Kitay / dau	oe, Print) nghter in law	19b. Mailir 3 Sano	ng Address de rs ((Street and Court,	Number or Rura Gaithe	al Royte Number, ersburg,	<i>Сі</i> рог 208 7	tate, Zip Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural, or items 23a or 28a-f show montant: If item 27 ie marked other then "natural, or items 23a or 28a-f show early injury or other traumatic event, the Medical Examinat must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furbral Service License	Ridgew Hebrew	vood, NY v Funeral Home						
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8760,	taw requires that the death certificate be executed as been signed by the attending physicien and in property of the standing physicien and the standing physicien and the standing physicien and the standing physicien are the standing physician at the s	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection). Due to (or as a consection). Due to (or as a consection).	quence of):						
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۵.	uires that the de n signed by the a lid be detached i		Part It. Other significant conditions con	ntributing to death but not re	sulting in the u	inderlying ca	ause given ir	n Part I.			bute to the cause of death?
al Recol	The ate h page	Completed								y pr ned? de DENo 1	/ere autopsy findings available rior to completion of cause of eath? □ Yes 2□ No
Division of Vital Records,	ing Phys. After this uneral di	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	lospital: 1 Inpatient 2 [28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		Other: 8c. Injury at Work?	4 🗆 Nursing Ho	h <i>(Check only on</i> ome 5 ☐ Reside 28d. Describe ho	nce 6 Othe	
Divisi	Itel or Attending rs after death. rel Director: After led in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Ptace of tnjury - At l building, etc. (Spec	home, farm, st.	reet, factory			28f. Location (St City or Town		or or Rural Route Number,
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)	Within To the Comp	×	29b. Signature and title of certifier	ing mi	>		D313		1	od. Date signed	(Month, Day, Year)
	y		30. Name and address of person who as Suhair H. Abulfa:				rove F	Road, #1	100, Roc	kville,	MD 20850
1	Sta Regist		31. Date filed (Month, Day, Year) AUG 18 2	32. Registrar's Sign							

State of Maryland / Department of Health and Mental Hygiene 2006 = For State Registrar 28162 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** AUGUST 2006 1:33 P RICHARD CHRISTOPHER KEIM 16, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S BERWYN HEIGHTS 6005 PONTIAC ST. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 € M 2 □ F FEB. 16, 1950 WASH. Director 56 D.C. 261-04-1225 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County ir then "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be nutified at 1√2 Yes 2 No BERWYN HEIGHTS MD. PRINCE GEORGE'S Direct 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 6005 PONTIAC ST. 20740 U.S.A. death Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. e filed within 72 hours after If Hygiene. other then "natural", or ite 1 X Yes 2 No 1967-1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 1972 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) SELF EMPLOYED 12 HOME INSPECTOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 Ie marked oth eny injury or other treumatic event **LEONA** MARGARET ABBOTT CHRISTOPHER KETM WILLIAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6005 PONTIAC ST., BERWYN HEIGHTS, MD. 20740 KEIM/WIFE S. ANNE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 8-18-2006 RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 8 MONTHS PANCREATIC CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician end s the burial-transit The law requires that the daath certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ettending parties of for use es t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 2□ No this certificate 1 Yes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) ဥ 1 ☐ Yes 2 X No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Within 24 hours of To the Funerel 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature-and MD 941 use of death (Item 23a) (Type, Print) 30. Name and address of person 4201 MITCHELLVILLE RD. #102, BOWIE, MD. 20716 BRINGMAN M.D. KONNI 31. Date filed (Month, Day, Year) AUG 18 32 Registrar's Signature State 2006 Registrar

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06-06359

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State of Maryland / Department of Health and Mental Hygiene Marc A. Kremers 2006 28164 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day August 25, 2006 0918 hrs **Medical Examiner** Marc Alan Kremers 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death Worcester Berlin Atlantic General Hospital 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours June 9, 1929 Director Country) Wisconsir 396-24-7659 77 1 X M Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location Yes 2 X No 23a or 28a-f show notified at once. Fairfax Burke Virginia hours after death with the Maryland Director 10g Citizen of What Country 10e. Street and Number 10f. Zip Code U.S.A. 22015 9306 Windbourne Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. or items? Armed Forces? White, etc. 1 Never Married 2 X Married 1 X Yes No Yes 2 No specify: Specify Widowed Divorced If Yes. Give Year unk. White narked other than "natural", event, the Medical Examiner \$ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) es 1 and 2 should be filed within 72 of Health and Mental Hygiene ublic Relations Director NASA 5+ Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Grace Kalkhurst Marcus Otto Kremers marked Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) other traumat Va 22015 9306 Windbourne Road Burke. Marion Fleming Kremers/Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Fairfax Memorial Park Sep.1,2006 Fairfax, Virginia rtment o Important: injury or oth Donation 5 Other Specify 22. Name and Address of Facility 21, Signature of Funeral Service Licenses Fairfax Memorial Funeral Home 9902 Braddock Koad Fairfax, Virginia lema Towart 22032 M01338 23a. Part I. Anter the disease or complication failure. List only one oause on each line Approximate Interval or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and /Medical Death Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter University Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical X UNPENDED the attending physician ed for use as the burial -AMENDED item#23a,27,perME,g859,9/18/06 TT Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown signed by the a 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ð 1 Yes 2 No 3 Probably 4 V Unknown Completed s been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed' Yes 2 V No 26 Place of Death (Check only one) 25. Was case referred to medica Be Other₄ examiner? Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 After this 2 No ٥ 1 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 27, Manner of Death Certification: s after dean. 1 Natural 1 Yes 2 No 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 Could not be or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I and manner stated 29c. License number 29d. Date signed (Month, Day, Year) ture and title of certif O.C.M.E August 26, 2006 ween +1 lame and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. Assistant Medical Examiner 31. Date filed AVG Day Year Registrar's Signature State 2006 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200628165 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** August 17, 2006 5:31 Ruben Limpin Kabigting /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1(XM 2□F 219-63-1640 May 27, Philippines 1950 Director 56 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County ir than "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at Germantown 1 ☐ Yes 2 No Maryland Montgomery Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 12987 Middlebrook Road, Unit C 20874 **Philippines** Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 21X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify: Pacific Asian 5 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Real Estate 12 Real Estate Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be f ment of Health and Mental I ant; if item 27 is marked o Faustino Kabigting Pelagia Limpin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12987 Middlebrook Road, Unit C. Germantown, MD Florinda Kabigting/ Spouse item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place)
All Souls
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition Depertment of H
important: If ite
any injury or ot August 21, Germantown Maryland 3 Removal from State 1 Burial 2 ☐ Cremation 4 □Donation 5 □ Other (Specif) 22. Name and Address of Facility DeVol Funeral Home, 21. Signature of Juneral S 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Part1 Effet the diseas hock of heart failure. Immediate Cause (Final disease or condition resulting in death) isease, or complications that caused the ilure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** 90 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a Examine inding physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ۵ 1 Yes 2 No 3 Probably 4 Monknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has t irector, page 2 s 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 es 2 No 2 ✓ ER utpatient 3 DOA ٩ 1 🗌 Inpatient this After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Direct completely filled in by t 4 | Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar 29b. Signature and title of certifier

Gamma 31. Date filed (Month, Day, Year) AUG 2 1

Gamma, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

9901

Mulical

32 Registrar's Signature

10

29c. License number 15(980

Drive, Rockulle Md

State of Maryland / Department of Health and Mental Hygien 2006 28166 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Sterlina 921 PM ina ton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs. Months Days Hours Min. B. Date of Birth (Month, Day, Year Dec 22, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birtholace (State or Foreign Funeral 1**⊠**M 2□ F 89 171-05-6916 Pennsylvania Director 1916 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits item 27 is marked other then "neturel", or items 23s or 28s-f show other traumatic event, the Medical Examinational conditied at Westminster Maryland Carroll 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2214 Carrollton Road 21157 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after ☐Yes 2**%** No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white ð 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72: Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "netteny or other traumatic event, the Medical Once. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electronics Service Technician 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elmer Smith Sadie Sacks 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loraine E. Kraft, wife 2214 Carrollton Road, Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 08/25/2006 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee M01191 91 Willis Street, Westminster, MD 21157 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Intervat Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 Cavelie 1 **Physician** Heete /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. ed by the attending physicien detached for use as the buria Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of defivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 20 1 ☐ Yes to the Hospital or Attending Physicien: within 24 hours after death.
To the Funeral Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 I batient 2 ER/Outpatient 3 DOA 27. Manns Death 28b. Time of fnjury Certification: 28c. 28d. Describe how injury occurred 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifie Medical and manner stated. 29b. Signature 29c. License number WIL D39296 200 Memorial Ave. of death (Item 23a) (Type, Print) 4 WestminsterIND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Blown & Spark

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2006 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** ALLAN LONG, JR. AUGUST 9:30 PM KENNETH 19 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 29890 ROOFTOP CIRCLE MECHANICSVILLE ST. MARY'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Funeral 1√2M 2□F Days Hours 219-54-6178 Yrs. Director 53 4, 1952 WASHINGTON, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show Director 1 ☐ Yes 2 ☐ No MD ST. MARY'S MECHANICSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29890 ROOFTOP CIRCLE 20659 U. S. A. deeth \ Funeral 'neturel', or Iteme 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Follos: IXXYes 2 □ No If Yes, Give Year or Dates: 171-174 within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ 3 ☐ Widowed 4 ☑ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 ELEVATOR MECHANIC Pages 1 and 2 should be filed venout of Health and Mental Hygie int: if Item 27 is marked other I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ALLAN KENNETH LONG BETTY GIBBS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30281 GERSHWIN ROAD CHARLOTTE HALL, MD 20622
se of Disposition (Name of Date Date 20c. Location - City or Town, State DONALD E. LONG / BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 'Department of H Important: if ite any injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) VETERANS CEMETERY AUG. 24, 2006 CHELTENHAM, MARYLAND 22. Name and Address of Facility BRINSFIELD-ECHOLS FUNL.HME., P.A. tore of Funeral Service M00641 30195 THREE NOTCH RD. CHARLOTTE HALL, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** ESOPHAGEAL CARCINOMA ONE YEAR resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. attending physicien by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. the 9 Unknown 9 Unknown δ Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificete 1 Yes Division of Vital 2 € No Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending efter death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours e 29a. Certifier Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check or ly within 2 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D 44436 AUGUST 22, 2006 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) ASHVIN K. PATEL, M.D. 102 PAUL MELLON COURT #102 WALDORF, MARYLAND 20602 32. Régistrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 2 2006 Registrar

			For State Registrar	State of Marylan		ment of He			iene 2006	28168
	Physici		Decedent's Name (First, Middle, Last) Elnora Marguer	ite McCaf	ferty			2 Date of Death	Day Year	3. Time of Death
	/Medic Examin		Facility Name (If not institution, give st	reet and number) ice at the	1000	b. City, Town, or Lo	b wr	myus	4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. 94			f Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bi	nthplace (State or Foreign ountry)
	D.		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Locati	ion				10d. Inside City Limits
	8a-fsh	Director	Maryland Wicomic	o Sa	alisbury					1 K Yes 2 □ No
	th with th	ai Dire	10e. Street and Number 351 Deers Head Ho	spital Road		10f. Zip Code 21801		10	og. Citizen of What C USA	ountry?
980	72 hours after deeth with the Maryland natural; or items 23a or 28a-f show disal Examiner must be notified at	by Funeral	11. Marital Status 1: 1 Never Married 2 Married 3 Vidowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 █️No If Yes, Give Year or Dates:	If Ye	s Decedent of Hisp as, specify Cuban, Yes 2 X No	anic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	te, etc.
Maryland 21215-0036	within ene. then	Completed	15. Decedent's Educ. (Specify only highest grade		(Give kin	t's Usual Occupation of work done dur NOT use retired)		ing	Insurance	
land ?		To Be C	17. Father's Name (First, Middle, Last) Harry C. Hill			18	8. Mather's Name Minnie	Calloway	faiden Sumame)	
	alth a		19a. Informant's Name/Relationship (Type Patricia E. McCaf			Address (Street and 9 Philli	o Number or Run ps Ave.	Salisbu	City or Town, State, ury, MD 21	Zip Code) 804
Baltimore,	permit. Pages 1 and Department of Healt Importent: If Item 2' any injury or other i		20a. Method of Disposition 1	moval from State W	lace of Disposition of Company of	memorial Memorial	1	5/06	Salisbury	
Balt	permit. Departr Importe any nij		A A C		FSP 221N	T1300 Address SNOW H	uheral E	Home Pro	fessional ry, MB 21	Association 804
	Physician		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the deatl	h. Do not enter t	he mode of dying,	_	or respiratory arre		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions, b.	Due to (or as a consequence	uence of):		0			
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68760,	icate be executed physician and s the burial-transit	dicai	d.							
.O. Box (The law requires that the death certific lie has been signed by the atlending p age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ▷ No 9 □ Unknown	c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of di 9 Unknown	I death 3 □Ec	topic pregnancy ther (specify)			23d. Date of de Month	olivery Day Year
<u>α</u>	quires that n signed by uld be deta	Ď	Part II. Other significant conditions cont	ributing to death but not res	ulting in the unde	rlying cause given	in Part I.	23e. Did tob		o the cause of death?
Vital Records,		Completed						24a. Was ar autops perform 1 Yes 2	y prior to	utopsy findings available completion of cause of
Vita	sician: certific rector,	Be	25. Was case referred to medical examiner?	ospital:	500 · · · · ·	Other		h (Check only one		-
ion of		ation: To	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury a Work?			nce 6 □Other (Sp. w injury occurred	ecity)
Division	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 □ Suicide 6 □ Could not be 4 □ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street	, factory, office		28f. Location (Sti City or Town	reet and Number or F i, State)	Bural Route Number,
	the Hospithin 24 hour the Funeral mpletely fills	Medical (29a. Certifier (Check only one) Certifying Physical Examin	cian: To the best of my kno er: On the basis of examina and manner stated.	wledge, death or tion and/or inves	ccurred at the time, tigation, in my opin	date and place, ion, death occur	and due to the ca red at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the vithin	ž	29b Signature and title of certifier	200 MAN	`	29c. License n	number		9d. Date signed (Mon	
	311		30. Name and address of person who cor	npleted cause of death (Item	n 23a) (Type, Pri	nt)	BoxI	722	8-21.	MA 21602
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture Hosp	wills	Joyl	7)4 0)	7/102

ORIGINAL

			For State Registrar	State of Ma	arylan				ealth ar D <i>eath</i>	nd Mer	ntal Hyg ı	giene, Reg. No.	2006	28169
	Physicia /Medic	2.	Decedent's Name (First, Middle, Last	,	e C. N	Miller					Date of Dea Month	ath Day	7. 2006	3. Time of Death 7 15A M
	Examin		4a. Facility Name (If not institution, give 9925 Kivk	sville	Lai			Du	Location of	Death K	0	4c. (Calve	.r+
	Funeral Director		579-36-9194	ex 7. Ag □M 2□ X F	81	ast birthday) Yrs.	If Unde Months	Days	If Under 24 Hours	Min. 8.	Date of Birt (Month, Day Jan	h y, Ye <i>ar)</i> 2, 1925	9. Birth	place (State or Foreign htry) Maryland
	Aaryland f ehow	or	Usual Residence of Decedent 10a. State 10b. County MD Ca	alvert	10c. City	, Town or Lo	ocation		Dunk	irk				10d. Inside City Limits 1 ☐ Yes 2 ☐ Xo
	with the ha or 28a-	Director	10e. Street and Number 9925 Kirksville Lane		1		10f. Z	p Code	2075	4		10g. Citiz	en of What Cou	•
936	should be filed within 72 hours after death with the Maryland d Mental Hygiene. marked other then "naturel", or items 23e or 28e-f ehow matic event, the Madical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 The If Yes, Give Year or Dates:			Was Dece If Yes, spen	cify Cuba	spanic Origin, Mexican, Specify:	n? (Specify Puerto Ric	y Yes or No- an, etc.)		4. Race - Ameri Black, White, Specify: Bla	etc.
21215-003	ithin 72 ho ne. nen "natur	Completed	15. Decedent's Ec (Specify only highest gra	ducation ide completed) College (1-4or	5+)	16a. Dece (Give life.	kind of w	ork done d use retired	lurina most a	of working			of Business/Ir	
and 21	be filed ital Hygi od other event, I	Be	12 17. Father's Name (First, Middle, Last)	Frank Albert F	Harvev			Oup		s Name (F	irst, Middle, Mary	Maiden S		
Maryland	2 4 5 5	၉	19a. Informant's Name/Relationship (Ronald G. Miller/son				-		and Number Blvd. Oxo				Town, State, Zij	o Code)
Baltimore,	@ O b		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Specification)			lace of Dispo emetery, crea		other plac	Θ)	Date 08/2		20c. Loc	cation - City or T Lothia	own, State n, MD
Balti	permit. Pege Department of Importent: if eny injury or		21. Signature of Funeral Service Licer	Sevell		22	2. Name a	nd Addres ewell F 451 Da	s of Facility uneral F ires Bea	lome ch Roa	d Prince	Frede	rick, MD 20	0678
8760,	Physician be executed /Medical Examiner purial-transit	al Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	ine. riosc a consequence a consequence c	lerot uence of): usur uence of): hi (e.	ie (Carc	liova				ase	Approximate Interval Between Onset and Death
P.O. Box 687	The law requires that the death certificate ate hes been signed by the ettending phy. page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 moetfs? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	2 Fetal	death 3	⊒Ectopic ☐ Other (s	oregnancy pecify)				2	3d. Date of deliv	ery Day Year
ds, P	uires that n signed b ld be deta	þ	Part II. Other significant conditions of	contributing to death t	out not resi	ulting in the u	ınderlying	cause give	en in Part I.					the cause of death?
Division of Vital Records, I	The law require ete hes been siç page 2 should b	Completed								_	24a. Was autor perfo 1 Yes	osy rmed?_	24b. Were autoprior to condeath?	opsy findings available ompletion of cause of 2 No
Vita	yelcisn: The is is certificete he director, page 2	To Be (25. Was case referred to medical examiner?	Hospital:	ent 2	ER/Outpatie	nt 3∐ 0	Oth			heck only o		☐Other (Speci	(v)
ion of	nding Phy ath. r: After this e funeral c		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Inju (Month, Da	ury	28b. Time of Injury		28c. Injury World		280	1. Describe I			<i>y</i> ,
Divis	To the Hospital or Attanding Physicism: within 24 hours efter death. To the Funeral Director: After this cartifica	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of In building, e	jury - At ho tc. (Specif	ome, farm, st	reet, facto	ry, office		281	Location (S City or Tox			al Route Number,
	Hospital 24 hours Funeral letely filled	Medicai		nysician: To the best miner: On the basis of and manner s	of examina									
	To the twithin 24	Me	29b. Signature and title of certifier	0.0		NII	2	9c. Licenso				29d. Date	e signed (Month	Day, Year)
,	0		30. Name and address of person who			1 23a) (Type,	, Print)	y4	1945	,		08	11+10	6
	Ä		CIELITO A	GMIN	AL.	DU _				<u>L</u> a	rg0,	4	D	
	Sta Regista		31. Date filed (Month, Day, Year)	32, Hegist	rar's Signa	Anach	23							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes of Co.

			1 - For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Mar	yland / Depa	rtificate of L	ealth and M Death	2. Date of Death	g. No.	3. Time of Death
	Physicia /Medic		Barbara Ann Moy	er				Month August 1	Day Year .6, 2006	8:30 p M
	Examin		4a. Facility Name (If not institution, give si	·		4b. City, Town, or			4c. County of Dea	ath
			Holy Cross Hospit				Spring			lontgomery
ŀ	Funeral Director		210-30-2013	7. Age (i	n yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, July 18,	^{9. Bi} 1927 Was	othplace (State or Foreign Sountry) Shington, DC
	ehow	Ž	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2√ No
	he M	Director	Maryland Montgome 10e. Street and Number	ry	Silver	Spring		10	g. Citizen of What C	
	with with Lbs.	ā	10811 Inwood Aven	110			902		USA	ountry:
	ne 23	Funeral		2. Was Decedent Eve	er in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Race - Am	
2	urs after o al', or ites xaminer	þ	1 ☐ Never Married 2 ☐ Married 3 🙀 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		Rican, etc.)	Black, Wh.	
5	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: if tiem 27 is marked other than "natural" or iteme 23a or 28a-f show eny injury or other treumatic event, the Medical Examinar must be notified at once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done o DO NDT use retired,	luring most of worl	king	6b. Kind of Business	s/Industry
7	d with	E	Ciginalitary/Decordary (0 12)	2	Rec	gistered 1	Nurse		Hea	1th Care
2	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last) Ellis Wells Smith				18. Mother's Nam	e (First, Middle, M	laiden Sumame)	
2	Ment Ment arked	ပို					Lucy Ma			
<u> </u>	2 sh and re m		19a Informant's Name/Relationship (Type Lillian A. DeMerit			-			City or Town, State,	
ນົ ປີ	1 and Health em 27 ther t		20a. Method of Disposition					_	Oc. Location - City o	
Dalling	Pages ment of tant: if its		1 ★ Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	mioval irom State		osition (Name of matory or other place even Cemeter	Augus	t 21,	100	ing, Marylan
Da	permit Depart Import eny in		21. Signature of Funeral Service License	tielles	F1 50	Rancis J. Tancis J. 00 Univers	Collins sity Blvc	Funeral d, W, Sil	Home Inc. ver Sprin	g, MD 20901
		U	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the cause on each line.	e death. Do not ent	ter the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pneumonia	l					Onset and Death Davs
	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):					
	- Administra	<u>.</u>	Sequentially list conditions, b.	Esophagea						Years
	ted nsit	뒫	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	000 10 (31 43 4 6	onadquence dry.					
0070	icate be executed physicien and s the burial-transit	al Examiner	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):					
0	ifficate g phy as the	edical	0.					-		·
O. DOX	The law requires that the death certificate be executed site hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	lc. If yes, outcome of 1□Live birth 2 [4□Pregnant at tin 9□ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Y <i>e</i> ar
ŗ.	that the ded by detail		Part II. Other significant conditions con-	ributing to death but r	not resulting in the u	inderlying cause give	n in Part I.	23e. Did toba	acco use contribute	to the cause of death?
colds,	uires n sign id be	d by	Chronic Obstructiv	e Pulmonar	y Disease	≥,		1 ☐ Yes	s 2 □ No 3 □ F	Probably 4 ⊠Unknown
5	w reg	Completed	Anemia of Chronic	Blood Loss				24a. Was an	24b. Were a	autopsy findings available ocompletion of cause of
ב	The la	E	THICKER OF CHICKE	DIOCC LOSS	·			autopsy perform 1 Yes 2	ed? death?	completion of cause of
10	ian: '	BeC	25. Was case referred to medical				26. Place of Dea	th (Check only one		3 2 10
	Phyeician: The lav this certificete hes ral director, page 2	Tof	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1x Inpatient	2 ER/Outpatier	nt 3 DOA Othe	or: 4 🗀 Nursing H	ome 5 🗆 Resider	nce 6 □Other (Sp.	ecify)
5	ng Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time o	of 28c. Injury Work	at ?	28d. Describe how	w injury occurred	
INISIO	tendi eath. tor: A the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				res 2□No			
	tal or At rs after d et Direct ed in by	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, sti (Specify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or F State)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edicai	29a. Certifier (Check only one) 2 Medical Examin	ician: To the best of re: On the basis of exand manner state	camination and/or in	h occurred at the tim vestigation, in my op	e, date and place pinion, death occu	and due to the car rred at the time, da	use(s) and manner a te and place, and du	as stated. ue to the cause(s)
	To ti Withi To ti comp	M	29b. Signature and title of certifier			29c. License		29	d. Date signed (Mor	
	(0		maa ma			D32	2332		August 1	7, 2006
	,		30. Name and address of person who con Suresh K. Gupta, M			·	20, Silve	er Spring	, Md 2090	2
	Sta		31. Date filed (Month, Day, Year) AUG 18 200	32 Registrar's	Signature	wh)				

Registrar DHMH 16 Rev 6/95

State

SORESHKUNAR MUTTATH.

2006

32. gistrar's Signature

31. Date filed (Month, Day, Year) AUG 18

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

			1- State of Maryland / De State of Maryland / De	partment of Hea ertificate of De	alth and M eath	ental Hygi	ene 2006	28172
1	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Edward Richard McDaniel 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loc		August 1	6, 2006 Year	4:35 A M
)	Examin	er	Holy Cross Hospital	Silver Sp			Montgome	
	Funeral	_	5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	ay) If Under 1 Year If	Under 24 Hrs.	8. Date of Birth (Month, Day,	9 Birth	hplace (State or Foreign untry)
	Director		136-12-9053 12M 2□F 89 Yrs	Months Days H		June 28,		Jersey
	and		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town o	Location				10d. Inside City Limits
	Maryl	tor	Maryland Montgomery Wheaton					1 ☑ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number	10f. Zip Code		10	g. Citizen of What Co	untry?
	death with the Maryland me 23a or 28a-f ehow firtual be rigitied at	ai D	2809 Byron Street	20902			U ni ted Sta	ites
	teme	Funeral	Armed Forces?	 Was Decedent of Hispa If Yes, specify Cuban, M 	nic Origin? (Spe Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
20	rs afte	by Fi	1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 📆 No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 21X No Si	Specify:		Specify:	American
12-0036	be filed within 72 hours after death with the Marylan stall Hygiane. Id other than "natural", or Itema 23a or 28a-1 show a other, The Medical Examinar must be notified at	ed t	15. Decedent's Education 16a. De	cedent's Usual Occupation	n	1	6b. Kind of Business/	
212	hin 7.	pie	(Specify only highest grade completed) (G	ive kind of work done durin a. DO NOT use retired)	ng most of workir	ng		21
7	ed wil	Completed	5+ Psy	chologist			Howard Uni	versity
	tal H d off	Be	17. Father's Name (First, Middle, Last) Edward McDaniel, Sr.		. Mother's Name Nancy C	(First, Middle, M	aiden Sumame)	
Maryland	2 should be filed very and Mental Hygia is marked other feumatic event, in	10		ailing Address (Street and			City or Town State 7	in Code)
2	th an lith an 27 is it treu		Constance Richardson (stepdaughter)					
ē,	item other		20a. Method of Disposition 20b. Place of Di	sposition (Name of crematory or other place)			oc. Location - City or	
Ē	Page Int. II		1 10 Burial 2 I Cremation 3 I Hemoval from State I	coln Cemeter	у 8/24	4/06 B	rentwood,	Maryland
saitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other treumatic ex page.		21. Signature of Funeral Service Licensee	22. Name and Address of				
	205 g			7400 Georgia				
			23a. Part1. Enter the disease, or complications that cau set the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, sa	uch as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Severe Dehydr	ation				
	Examiner		Due to (or as a consequence of): Failure to th	ri ve				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying					
	ocuted nd transi	Examin	that initiated events c.					
Ď,	icate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of):					
09/89	death certificate be executed e attending physician and nd for use as the burial-transit	dical	d					
XO	leath certific attending p i for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	_			23d. Date of deli	verv
Ď	death e atte	icia	in the past 12 months? 1 Ves 2 No 4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)			Month	Day Year
5	at the d by th stache	Phys	9 Unknown					
Ś	requires that the de een signed by the a nould be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the Myeloproliferative disorder	e underlying cause given in	n Part I.		icco use contribute to	the cause of death?
	peer peer hou	eted						
a)	e la has	Completed	Splenic lesions undetermined etiolo	ogy		24a. Was an autopsy	prior to c	topsy findings available completion of cause of
	iician: Th certificate rector, pag	ပိ	25. Was case referred to medical	26	Place of Death	1 Yes 21	No 1 ☐ Yes	2 🔀 No
>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2X No Hospital: 1X Inpatient 2 ☐ ER/Outpa	Othor			ce 6 Other (Spec	cify)
n or	ng Ph fter th merai		27. Manner of Death 28a. Date of Injury 28b. Tim 1 X Natural 5 ☐ Pending (Month, Day Year) Inju	e of 28c. Injury at		28d. Describe hov		
<u> </u>	tendi leath. tor: A the fu	cati	2 Accident investigation		2 🗆 No			
DIVISION	or At after c Direc in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	2	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number.
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funarel Director: After this certific completely filled in by the funeral director,	<u>cc</u>	29a. Certifier 12 Cartifying Physician: To the best of my knowledge, d	eath occurred at the time. o	date and place. a	and due to the car	ise(s) and manner as	stated.
	ne Ho n 24 h ne Fui	edic	(Check only one) 2 Medical Examiner: On the basis of examination and/o	r investigation, in my opinio	on, death occurre	ed at the time, dat	e and place, and due	to the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier	29c. License nu			d. Date signed (Month	
	0		· Choolondan	DR63579		A	ugust 16,	2006
	0		30. Name and address of person who compiled cause of death (Item 23a) (Ty Maria J. Tayag, M.D. 1500 Forest (ilver Sn	ring MT	20910	
	Sta	te			river ph	-+11g, Ill	20710	
	Registr		AUG 2 1 2006 Brown &	parti				

		ľ	For State Registrar	State of Maryla		tificate c			ig. No.	20170
ı	Physici		JOHN A. MANFIISO IR						Day Year	3. Time of Death 5:26am
	/Medic Examin		4a. Fecility Name (If not institution, give st			4b. City, Town	n, or Location of Death		4c. County of Death	
			Suburban Hospital			Bethe	esda		Montgome	ry
	Funeral		5. Social Security Number 6. Sex		. last birthday)	If Under 1 Ye Months Da		8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign intry)
	Director			^{M 2□F} 76	Yrs.	Month Da	70 115610 111111	Sep 6,1		nington DC
	and		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. fnside City Limits
	daryli f eho	ō		ch County	Manalan					1 ☐ Yes 2 ☐ No
	the t	ect	10e. Street and Number	en county .	Manalap	10f. Zip Cod	e	11	Og. Citizen of What Cou	intry?
	3a or	Funeral Director	550 S. Ocean Blvd.			33	462		United Stat	tes
	death	nera	11. Marital Status	2. Was Decedent Ever in	U.S. 13.		of Hispanic Origin? (Sp Suban, Mexican, Puerto		14. Race - Amer	ican Indian,
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Iteme 23a or 28e-f show aumatic event, the Medical Examiner mant be notified at	by Fui	1 □ Never Married 2 Married . 3 □ Widowed 4 □ Divorced	Armed Forces? 1 X Yes 2 1 No. 1 If Yes, Give 1951 Year or Dates: 195	to	1 Tes, specify C		nican, etc.)	Specify: White	
Š	2 hou		15. Decedent's Educ	ation	16a, Dece	dent's Usual Do	cupation		16b. Kind of Business/li	ndustry
212	b. "n	Completed	(Specify only highest grade Efementary/Secondary (0-12)	Colfege (1-4or 5+)	life.	DO NOT use re	ne during most of work tired)	king		
2	or the	5		4	Busi	ness Ow	1		Business	
ם	be filed tal Hygie d other event, III	Be (17. Father's Name (First, Middle, Last)	1				ne (First, Middle, A	Maiden Sumame)	
<u>X</u>	should be and Mental marked o	2		r.	1		!	Tyree		
Jai	2 sh and le m		19a. Informant's Name/Relationship (Typ						City or Town, State, Zi	
e)	1 and 2 Health em 27		Yardley Manfuso/ W 20a. Method of Disposition		550	S. Ocea	n Blvd., M	analapan _{Date}	Florida 33	N462
õ	nent of h		1 Burial 2 □ Cremation 3 □Re			sition (Name or natory or other				
Baltimore,	permit. Pages 1 and 2 should I Department of Health and Meni Important: If item 27 le marke eny Injury or other traumatic once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lipense			n Cemet	1		Rockville,M er's Sons,I	
Ba	permit. Departm Importa eny Inju		Willary R.	Bugge					shington DC	
П			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the dea	ath. Do not ent	er the mode of	dying, such as cardiac	or respiratory arre	est,	Approximate fnterval Between
	Physician		Immediate Cause (Final disease or condition	Cadiopulme	onary A	rrest				Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):							
ı	<u> </u>	_	Sequentially list conditions, b.	Coronary Due to (or as a conse		Disease				
	ted nslt	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (0) 23 2 20132	iquonica or _i .					
	be executed siclen and burial-transit	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):							
68760,	ificate be executed g physicien and is the burial-transit		d.							
89		ledicai								
Box	leath certifii attending (I for use as	Physician/M	230. Was decedent program	c. ff yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pregna	ancv		23d. Date of deliv	•
m C	deat deatt	sicie	in the past 12 months? 1 Yes 2 No	4☐ Pregnant at time of 9☐ Unknown		Dther (specify			Month	Day Year
о. О.	et the de I by the a etached	Phy	9 Unknown					00 - Di () - I	1	ot
Division of Vital Records,	The law requires thet the death cert Ne has been signed by the attendin page 2 should be detached for use	ρ	Part II. Other significant conditions cont Renal Cell Cance	_	sulting in the u	nderlying cause	given in Part I.	23e. Did tot	pacco use contribute to es 2 □ No 3 □ Pro	v
<u>ဂ</u>	s been si s should t	Completed	Alzheimers Disea	se				24a. Was a	n 24b. Were aut	opsy findings available ompletion of cause of
Ä	hysiclen: The lav his certificete has I director, page 2	E O						autops perforr 1 Yes 2	y prior to c ned? death? 2.44 No 1 □ Yes	
ā		0	25. Was case referred to medical			C 10 PER 17 17 10 10 10 10 10 10 10 10 10 10 10 10 10	26. Pface of Dea	th (Check only on		20110
>	nysici nis ce direc	To B	examiner? X 1 \(\text{Yes} 2 \) No	ospital: 1 🗌 Inpatient 2 l	☐ ER/Outpatier	nt 3 DOA	Other: 4 Nursing H	ome 5 Reside	ence 6 □Other (Spec	ify)
0	ng Pt fter th neral		27. Manner of Death 1 △Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		njury at Work?		w injury occurred	
<u>S</u>	Attending Physiclen: r death. ector: After this certific by the funeral director,	catio	2 Accident investigation			М	1 ☐ Yes 2 ☐ No			
Ë E	To the Hospital or Attending Ph within 24 hours eiter death. To the Funeral Director: After th completely filled in by the funeral	Certification	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, sti cify)	reet, factory, off	ice	28f. Location (St City or Town	reet and Number or Rui n, State)	ral Route Number,
	Hospital or 24 hours efte Funeral Dir etely filled in		29a. Certifier 1 Certifying Physi	cian: To the best of my k	nowledge, deat	h occurred at th	e time, date and place	, and due to the ca	ause(s) and manner as	stated.
	e Fur	edical	(Check only 2 Medical Examin	er: On the basis of examinand manner stated.	nation and/or in	vestigation, in r	ny opinion, death occu	rred at the time, d	ate and place, and due	to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier	-		29c. Lic	ense number	2	9d. Date signed (Month	, Day, Year)
	50		1/2 CAP2	our		МІ	40576		August 19,	2006
	50		30. Name and address of person who con							
_			Ramin Oskout,M.D			Ave, N.W	. Washingto	on DC 200	016	
	Sta		31. Date filed (Month, Day, Year) ALIG 2 1 200	32 Registrar's Sig	nature	asti)				

0526

State of Maryland / Department of Health and Mental Hygienes Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUG. 2006 Physician 20, 8:55 P M Venkat Mani /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S SOUTHERN MD HOSPITAL SUB ACUTE CARE CLINTON II Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. (Month, Day, Year)
July 12, I 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign
Country) **Funeral** 1**X** M 2□ F 60 India Director 578-76-6400 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Alexandria Virginia Fairfax 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22307 USA 1806 Windmill Lane Pages 1 and 2 should be filed within 72 hours after death vant of Health and Mental Hygiene.
and: it flew 27 is marked other then "natural", or items 23s try or other treumatic event, it as Medical Examination must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married Married Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Indian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Health Medical Doctor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (Seethalakshmi Krishnaswamy Krishnaswamy T.V. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1806 Windmill Lane, Alexandria, VA 22307 Nish Mani - Son Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Dapartment in important: tf any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 8-23-2006 Arlington, Virginia No. VA Crematory 22. Name and Address of Facility M00053 HUNTT FUNERAL HOME, P.O.BOX 156, WALDORF, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner 06HCEKU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury by Physician/Medical Examiner Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 **N**0 Be 25. Was case referred to medical examiner? 26. Place of Death |Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 Tes 2 No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number. City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 1 x Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Chack only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) 2010 OCD LINE CENTER WALDORF, Md. 20602 \$ 10 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygien 2006

			1 - For State Registrar		Ce	rtificate c			eg. No.	6 28113
	Physici	an	Decedent's Name (First, Middle, Last) THELMA DELICITION TO TO.	NICON MATT	THE TO			2. Date of Dea Month	Day Y	3. Time of Death
	/Medic Examin	cal	THELMA DELOIS JOH 4a. Fecility Name (If not institution, give si		THEWS	4b. City. Tow	n, or Location of D	AUGUST	18, 200	
1	Exami	iei	SOUTHERN MARYLAND				CLINTON			GEORGES
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birthday	If Under 1 Ye Months Da		Hrs. 8. Date of Birth (Month, Day FEB 23	Year)	Birthplace (State or Foreign Country)
	Director		214-30-2452	M 2√2 F	72 Yrs.			FEB 23	, 1934	MARYLAND
	yland sow		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	a-f et	ctor	MD CHARLES		LAPLATA					1 X Yes 2 □ No
	or 28	Dire	10e. Street and Number			10f. Zip Cod			0g. Citizen of Wh	,
	eath v	eral	115 PENDER DRIVE	2. Was Decedent E	ver in II S 12		546		UNITED S'	TATES - American Indian,
36	be filed within 72 hours after death with the Maryland stal Hygiene. Id other then "natural", or iteme 23a or 28a-f ehow event, the Midical Erapinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 21☐ N If Yes, Give Year or Dates:	lo	If Yes, specify C		? (Specify Yes or No- uerto Rican, etc.)		White, etc. BLACK
21215-0036	2 hou	ted	15. Decedent's Educ	ation	16a. Dece	dent's Usual Oc	cupation		16b. Kind of Busi	
215	ithin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	+)		ne during most of ired)	working		
121	filed w Hygier ther th		10 17. Father's Name (First, Middle, Last)		SUPE	RVISOR	10 Mathada	Name (First, Middle, i		GOVERNMENT
Maryland	2 should be filed within and Mental Hygiene. Is marked other then aurmatic event, the M	To Be	GUY WATSON					MILY JOHNS		
ary	s 1 and 2 should I Heelth and Men Item 27 is marke other traumatic	Ĕ	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mail	ng Address (Str		Rural Route Number		
	s 1 and 2 of Heelth a ltem 27 is other tran		CHARLENE MATTHEWS/D	AUGHTER	115	PENDER I	DRIVE, LA	PLATA, MA	ARYLAND 2	20646
Baltimore,			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	moval from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other)	olace)		20c. Location - C	
Ħ	permit. Page Department of Important: If eny Injury or once.		4 Donation 5 Other (Specify)	10	SACRED H			'26/2006 I	LA PLATA	, MARYLAND
Ba	permit. Page Department of Important; if eny injury or once.		21. Signature of Funeral Service Liceral LADIA C. THORNT	ON JOHNSO	3	Name and Ad THORNTON 3435 LIV		ROME INDI	IAN HEAD,	, MD 20640
н			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	cause on each lin	Θ.		^		est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		NCHOGE	NIC	CHILL	MONA		1
	Examiner			Due to (or as a	a consequence of):					
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a consequence of):					
	tificate be executed g physician and as the burial-transit	Examln	Cause (Disease or injury that initiated events resulting in death) Last	Due to /or on	a consequence of):					
68760,	be exician burial			Due 10 (01 #2 8	consequence on.					
687	cate phy:	edlcal	d.							1
Box	eath certifi attending I I for use as		230. was decedent pregnant	ic. If yes, outcome		⊒Ectopic pregna	nav		23d. Date	of delivery
. B	The law requires thei the death cer tie has been signed by the attendir age 2 should be detached for use	Physician/N	in the past 12 months? 1 ☐ Yes 2 D(No	4☐Pregnant at		Other (specify,			Month	n Day Year
P.0	thet the de led by the a detached t	Phy	9 ☐ Unknown Part II. Other significant conditions cont	ributing to death bu	it not resulting in the i	Inderlying cause	given in Part I	23e Did to	hacco use contrib	ute to the cause of death?
Records,	uires the signed Id be de	d by	HYPERTER		it not rooting in the	indurying cause	given in raici.	100		☐ Probably 4 ☐Unknown
S	w requires been si should	Completed						24a. Was a	n 24b. We	ere autopsy findings available
Be	The lav	шо						autops	ry pric ryd? dei	or to completion of cause of ath? Yes No
		Bec	25. Was case referred to medical examiner?				26. Place of	1 ☐ Yes Death (Check only on	-	7410
of V	Physicien: rthis certific ral director,	္ပ	1 ☐ Yes 2 XNo	7 1	nt 2□ER/Outpatie	nt 3 DOA	Other: 4 Nursin	g Home 5□Reside		
	ding Pt	:lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. ₹ate of Injur (Month, Day	y 28b. Time o Ye <i>ar)</i> Injury	V	njury at Vork? □ Yes 2 □ No	28d. Describe ho	ow injury occurred	
Division	or Attending effer death. Director: After in by the fune	flcat	Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ıry - At home, farm, st			28f. Location (St	reet and Number	or Rural Route Number,
ă	o afe ⊑	Certification:	4 Notticide	building, etc				City or Town		
	To the Hospital within 24 hours of the Funeral completely filled	Medical	29a. Certifier 1 Certifying Physic (Check only 2 Medical Examin one)	cien: To the best of the control of the control of the control of the control of	examination and/or in	h occurred at the vestigation, in m	e time, date and pl y opinion, death o	ace, and due to the cocurred at the time, d	ause(s) and mann ate and place, and	ner as stated. d due to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	/^.			ense number		/ 4	Month, Day, Year)
			· VIII	My			1)538	85	8/20	12006
(Ra		30. Name and address of person who com	npleted cause of de	sath (Item 23a) (Type 50 Po (7 o	Print)	COAD # 3	RUY WA	works !	/2006 MD 20602.
	Sta	ite	31. Date filed (Month, Day, Year)	32. Reistra	r's Signature	1		· ·		

			For State Registrar	State of Man	yland / D (epartment of Certificate of	Health and I Death	Mental Hy	giene Reg. No.	06	28176
			1. Decedent's Name (First, Middle, Last)					2. Date of De	eath Day	Year	3. Time ol Death
	Physici /Medio		Mary E	izabeth	Near	ina			16, 200		12:35p M
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of Death		4c. County	ol Death	
			3435 South Leis				Spring		Montg		
П	Funeral		Social Security Number 6. Sex	M okie	n yrs. last birth	Months Days		8. Date of Bir (Month, Da	y, Year)	9. Birthp	place (State or Foreign ntry)
	Director		578-10-3756 Usual Residence of Decedent	96) '	rs.		Sep. 8	, 1909		VA
	land ow		10a. State 10b. County	10	Oc. City, Town	or Location	· · ·			1	0d. Inside City Limits
	Mary Hed	to	MD Montgom	erv	Silvo	r Spring					1 ☐ Yes ŽŽNo
	1 28s	Director	10e. Street and Number	ery	DIIVE	10f. Zip Code			10g. Citizen of W	hat Cour	ntry?
	3a o		3435 South Leisure	World Bly	d #B	20906			USA		
	deati	Funeral		Was Decedent Ever Armed Forces?		13. Was Decedent of	Hispanic Origin? (S	pecify Yes or No	- 14. Race		can Indian,
36	be filed within 72 hours after death with the Maryland ital Hygiene death of them "natural", or items 23a or 28a-f ehow other then "natural", or items 23a or 28a-f ehow event, the Medical Examinat must be notified at	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 🛣 No If Yes, Give		1 ☐ Yes 2 ☒ No	ban, Mexican, Puèrti Specify:	nican, etc.)	Specify:	c, White,	
Maryland 21215-0036	ural',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	10					WIT	nite
5	within 72 ene. then *nat	Completed	15. Decedent's Educ (Specify only highest grade	completed)		Decedent's Usual Occi 'Give kind of work don life. DO NOT use retir	during most of work	king	16b. Kind of Bu	siness/Ind	dustry
12	withi ene. then	шc	Elementary/Secondary (0-12)	College (1-4or 5+)		ll Appliand	•		Hogh+ C	'omn a	ny (Retail
2	filed Hygid		17. Father's Name (First, Middle, Last)	<u>. </u>	Dilla.	ri Appilano		ne (First, Middle,	, Maiden Sumame		my (Recall
an	ld be ental ked c	To Be	Reginald Warren Ki	dwell			Mary	Elizabe	th Madde	n	
3	2 should be filed and Mental Hygi ie marked other aumatic event, I	_	19a. Informant's Name/Relationship (Typ	pe, Print)	19b.	Mailing Address (Stree	t and Number or Ru	ral Route Numbi	er, City or Town, S	State, Zip	Code)
	and 2 ealth a n 27 is		Reginald K. Nearin	g / son	582	25 Northwes	st 75th Av	re., Oca	la, FL 3	4482	
ē,	it and the state of the state o		20a. Method of Disposition			Disposition (Name of , crematory or other pl		Date	20c. Location - (
Ĕ	Pages nent of nnt: If it		iXXBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	Silioval from State		11 Cemetery		19, 20	06 Suit	land	, MD
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 ie marked eny Injury or other traumatic ev page.		21. Signature of Funeral Service Licen	20		22. Name and Addi	Collins Fune	ral Home,	Inc.		
			23a. Part1. Enter the disease, or complic	cations that caused the	e death. Do no	500 University				MD 20	901 Approximate
	Dhusisian		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.		,	3,		.,		Interval Between Onset and Death
Ì	Physician /Medical		disease or condition resulting in death)	Dementia		n.					
	Examiner			Due to (or as a c	onsequence of).					
		Je.	Sequentially list conditions, if any, leading to immediate gause. Enter Under ying	Due to (or as a co	onsequence of):					
	outed od ansit	Examiner	Cause (Disease or injury that initiated events								
o,	be executed sicien and burial-transit		resulting in death) Last	Due to (or as a co	onsequence of	i):				7.1	
98760	ificate be executed g physicien and as the burial-transit	edical	L d								
-		Med	IF FEMALE:								
Box	death certi e attending id for use a	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐	Fetal death	3 □Ectopic pregnan			23d. Date Mon		ery Day Year
д О.	0 0 0	by Physician/M	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4□Pregnant at tim 9□Unknown	e ol death	5 ☐ Other (specify)					
	that II	P.	Part II. Other significant conditions con	tributing to death but n	ot resulting in	the underlying cause o	ven in Part I.	23e. Did t	obacco use contri	bute to th	ne cause of death?
Vital Hecords,	S F 8		Hypertension					10	Yes 2∑No	3 🗌 Prob	ably 4 □Unknown
ပ္ပ		Completed						24a. Was		ere auto	psy lindings available
Ä	sicien: The law certificate has irector, page 2 a	E o						autor perfo	prmed? pr	ior to cor eath? □ Yes	npletion of cause of
Ē	rtifica	0	25. Was case referred to medical		-		26. Place of Dea	1 ☐ Yes			2 140
>	Physic this ce al direc	ToB	examiner? 1 ☐ Yes 2XXNo H	ospital:	2 ER/Outp	patient 3 DOA	hoe		dence 6 Othe	r (Specify	v)
0	Attending Physicien: Ir death. •ctor: After this certific by the funeral director.		27. Manner ol Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	28b. Ti	me of 28c. Injury	ork?	28d. Describe I	how injury occurre	d	
<u> </u>	tendi leath. tor: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be			M 1[]Yes 2 □No				
Division of	고 함 다 드	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (- At home, farr Specify)	n, street, factory, office		28l. Location (3 City or Tox	Street and Numbe wn, State)	r or Rura	l Route Number,
	• Hospital or 124 hours after • Funeral Dir letely filled in	edical C	(Check only 2 Medical Examin	ician: To the best of mer: On the basis of ex	amination and	death occurred at the for investigation, in my	ime, date and place opinion, death occu	and due to the	cause(s) and mar date and place, a	ner as st	ated. the cause(s)
	To the within 2 To the Complet	Med	one) 29b. Signature and title of certifier	and manner stated	1.		se number		29d. Date signed		
	F ≥ F 8			_		D 58			8/18/20		,, , , , , , , , , , , , , , , , , , , ,
	20		30. Name and address of person who co	nnleted cause of door	h (Item 22a) (T		J U &		0/10/20		
							on MD 20	902			
	Sta	te	Shashank G. Patel, 31. Date liled (Month, Day, Year)	32 Registrar's	Signature	Mu., wheat	OII, MU 20	302			
	Registr		AUG 2 1 200	B Registrar's	1. A	Dave					

		Registrar	te of Maryland / Depa Cea	artment of H	lealth and M Death	Re	g. No.	
Physic /Med		Decedent's Name (First, Middle, Last) Gu	ssie OSHEROFF			2. Date of Death August	18 ^{ay} 2006 ^{ear}	3. Time of Death 10:15 A M
Exami Funeral Director	ner	4a. Fecility Name (If not institution, give street a 3310 N. Le1sure Wor1 5. Social Security Number 6. Sex 1 □ M X	d Blvd. #220 7. Age (In yrs. last birthday)	Silver	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 4.		thplace (State or Foreign buntry)
ס		Usual Residence of Decedent 10a. State 10b. County Maryland Montgomer	10c. City, Town or Lo	ocation Spring		APETT 4,	1913 Mar	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
h with the N 23a or 28a-1	al Director	10e. Street and Number 3310 N. Leisure Worl		10f. Zip Code 20906	5		og. Citizen of What Co	ountry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If tem 27 is marked other than "natural", or Items 23a or 28a-f show any injerrog other traumatic event, if a Medical Evartirar must be inclified at any injerrog other traumatic event, if a Medical Evartirar must be inclified at once.	by Funeral	1 Never Married 2 Married 1 V	Van OFTNa	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
within 72 ho piene. r than "natur	Completed	15. Decedent's Education (Specify only highest grade comp. Elementary/Secondary (0-12) Coll 12	ege (1-4or 5+) (Give life.	dent's Usual Occupa h kind of work done of DO NOT use retired	during most of work ()	ing	6b. Kind of Business Grocery S	
uld be filed Aental Hyg rked other	To Be C	17. Father's Name (First, Middle, Last)	nuel Rose		18. Mother's Nam	e (First, Middle, N Gorovoy		
i, IVICE y and 2 shore selth and N n 27 is ma		19a Informant's Name/Relationship (Type, Prir Sharon Kamerow, Daugl	1100 3100	N. Leisur	e World	31vd. #10	City or Town, State, . 04, Silver	20906 Spring, MD
Pages 1 ment of He tent: If the		20a. Method of Disposition 1. Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	from State 20b. Place of Disponsion State 20b. Place of Disponsion Commetery, creating the state of the state	osition (Name of matory or other place emorial Ga	08/20	06 ²	Oc. Location - City or Olney MD	Town, State
permit. Depart Import		21. Signature of Fundal Sarvice Licenses	To	2. Name and Address orchinsky	Hebrew F			20012
Physician /Medical		resulting in death)	that caused the death. Do not end e on each line. etastatic Pancre ue to (or as a consequence of):			of respiratory arre	g.con, Do	Approximate Interval Between Onset and Death Months
To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after cleath. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a consequence of): ue to (or as a consequence of):					
wrequires that the death certific been signed by the attending I should be detached for use as	Physician/Me	in the past 12-months?		□Ectopic pregnancy			23d. Date of de Month	livery Day Year
quires that ten signed by old be detact	ğ	Part II. Other significant conditions contributin		acco use contribute to	o the cause of death?			
ar neco	Completed						prior to death? No 1 □ Yes	utopsy findings available completion of cause of
siciar s certif irecto	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No Hospital	1 Inpatient 2 ER/Outpatier	nt 3 DOA Othe		h (Check only one	nce 6 Other (Spe	
To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	 		Date of Injury (Month, Day Year) 28b. Time o	of 28c. Injury Work		28d. Describe ho		City)
ital or Atta	Certification:	4 Homicide	Place of Injury - At home, farm, str building, etc. (Specify)			City or Town		
the Hosp. in 24 hou the Funer ipletely fill	edical	one) 2 Medical Examiner: On	To the best of my knowledge, deat the basis of examination and/or in i manner stated.	ivestigation, in my or	pinion, death occur	red at the time, da	ite and place, and due	e to the cause(s)
To T	Σ	29b. Signature and title of certifier	200	29c. License			d. Date signed (Moni	
6		30. Name and address of person who complete Linda M. Burrell, M.					August 18,	20902
St Regis	tate trar	31. Date filed (Month, Day, Year) AUG 2 1 2006	32 Registrar's Signature	all!	og 11 og 46 1	o, maa		

State of Maryland / Department of Health and Mental Hygiene Reg. N2006 For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2225 17, 2006 August Joseph Amos Purnell /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Worcester Berlin Atlantic General Hospital 8. Date of Birth (Month, Day, Year) If Under 24 Hrs Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours 1⊠M 2□F Months 87 Director June 16, Maryland 215-16-3255 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 10a State or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Berlin Worcester Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA or Items 23a 21811 10113 Germantown Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [∑Yes 2 ⊡ No If Yes, Give World Year or Dates:War II 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene.
7 Is marked other than "n Maryland 2121 National Artist College (1-4or 5+) Elementary/Secondary (0-12) Materials Supervison 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Le, Maryla.

Let Maryla.

Let Maryla.

Department of Health and Merlinportant: If Item 27 1any Injury or c... Sallie Miller Rufus Purnell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10113 Germantown Road - Berlin, Maryland 21811
to of Disposition (Name of Date 20c. Location - City or Town, State Marie Purnell/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Do 0 -- Baltimor 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 23, 2006 New Bethel UMC Cemetery Berlin, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1213 Jersey Road Jolley Memorial Chapel-Salisbury, MD 21801 23a. Part1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the. Approximate Interval Between Onset and Death Due to (or as a consequence of): Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and Due to (or as a consequence of): The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown NONE Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 No 1 Tes Division of Vital Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0050826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), thway Drive Selin MD 21811 A 9733 32. Registrar's Signature ENIOLA 31. Date filed (Month, Day, Year) AUG 2 2 2006 Registrar Maguer

Osep

			For Stete Registrar	State of M		partment of ertificate of		Mental Hygie	ne 2006	28179	
			Decedent's Name (First, Middle,	Last)				2. Date of Death Month	Day Year	3. Time of Death	
	Physici /Medic		Joan Margaret					Aug 20 20	006	1001 м	
	Examin	ier	4a. Facility Name (If not institution, g				or Location of Dea		4c. County of Death		
	Funeral		5. Social Security Number 6	Sex 7. A	ge (In yrs. last birthd	ay) If Under 1 Yea		s. 8. Date of Birth	Calvert 9. Birth	place (State or Foreign	
	Director		004-34-8849	1□ M 2□xF	58 Yrs	Months Day	s Hours Mir	July 9 ay 1	938 Main	ntry) e	
	land Sw		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits	
	Mary	tor	Maryland Calver	-	St. Lec	nard				1 ☐ Yes 2 ☐ M 30	
	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Items 23a or 28a-f show int. The Madical Examinat must be notified at	ai Director	10e. Street and Number 7521 Bond Street	et		10f. Zip Code 20685			. Citizen of What Cou United Sta		
	tems terms	Funerai	11. Marital Status	12. Was Deceden Armed Forces	?	3. Was Decedent of If Yes, specify Cu	f Hispanic Origin? (uban, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black, White,		
35	irs afte	by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 If Yes, Give Year or Dates		1 ☐ Yes 2 🗽 N	o Specify:		Specify: W	hite	
5-0036	72 hou	eted	15. Decedent's	Education	16a. De	ecedent's Usual Occ	upation se during most of w	orking 16	b. Kind of Business/Ir	ndustry	
2	ne.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) lif	e. DO NOT use retii	red)		civil serv		
N O	be filed with tal Hygiene. d other ther event. Ire M	e Co	17. Father's Name (First, Middle, La	st)	seci	etary	18. Mother's Na	ame (First, Middle, Ma		ice	
Maryland		To B	John Patrick Ric					tte Morin			
	nd 2 sh lith and 27 is m r treum	1	19a. Informant's Name/Relationship Eugene Pennington					Rural Route Number, C Leonard, I		o Code)	
altımore,	m O		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		cemetery,	sposition (Name of crematory or other p		4 2006	c. Location - City or T ince Frede		
	permit. Page Department Importent: If any injury or once.		* 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lic		SC. 001	n Vianney 22. Name and Add	lrass of Facility	-		IICK MD	
ñ	Dep Imp any		BROW	200		405 Broom		Rausch Fund d. Port Rei		20676	
0			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between								
	Physician		Immediate Cause (Final disease or condition resulting in death)		onary atteny	Luceure				Unknumn	
	/Medical Examiner		rosuling in assum,	Due to (or a	s a consequence of):						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a consequence of):						
	ecuted and transi	Examine	Cause (Disease of injury that initiated events resulting in death) Last	с							
8/60,	certificate be executed adding physician and use as the burial-transit		Todaling in dodain, Educ	Due to (or a	s a consequence of):						
9	ificate g phys as the	edicai		d			H-SM25000				
ROX	eath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth	e of pregnancy 2 Fetal death	3 □Ectopic pregnan	ncy		23d. Date of deliv	•	
Ċ H	D 00 0	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant : 9☐ Unknown	at time of death	5 Other (specify)			Month	Day Year	
7	law requires that the as been signed by th 2 should be detache		Part II. Other significant condition	contributing to death	but not resulting in th	e underlying cause o	given in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?	
<u>10</u> 8	w requires that been signed to should be deta	ed by	Metrolahic breast a	ance/				1 ☐ Yes	2 No 3 Prol	pably 4 Donknown	
Vital Hecords,	The law re	Completed			<u>-</u>			24a. Was an autopsy performed	d?prior to co	opsy findings available impletion of cause of	
<u>E</u>		BeC	25. Was case referred to medical examiner?					eath (Check only one)	1.0		
0	Phy this al d	၉	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpat	and the second second	Mair 3000		Home 5 Residence		(y)	
	fte ne	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	jury 28b. Tim lay Year) Inju	ry W	ork? □Yes 2□No	28d. Describe how	injury occurred		
DIVISION	al or Attendi safter death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could no 4 Homicide determin	286. Place of It	njury - At home, farm atc. <i>(Specify)</i>	street, factory, office	е	28f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,	
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edicai C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the bes aminer: On the basis and manner s	of examination and/o	eath occurred at the r investigation, in my	time, date and place opinion, death occ	ce, and due to the caus curred at the time, date	se(s) and manner as s and place, and due t	stated. o the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier				nse number	I .	. Date signed (Month,		
) acti			9	56024		20 August 1	200k	
	15		30. Name and address of person with Kenneth L. #1660H	- 110 tlos	potal Road	Sult 110	Prince Fro	edenik f(1)	20678		
Ì	Sta Registr		31. Date filed (Month, Day, Year)	2 2 2006	tradis Signature	x Sperti	,				

28180

			1 - For State Registrar	, , , , , , , , , , , , , , , , , , ,	Certificate	of Death		Reg. No.	20100
			1. Decedent's Name (First, Middle, Las	st)			2. Date of Dea	ath Day Year	3. Time of Death
	Physici /Medio		Lloyd Elmer Pa	tten				16, 2006	1:20 a ^M
a Line	Examir		4a. Facility Name (If not institution, give	e street and number)	4b. City, To	wn, or Location of Dea	th	4c. County of De	ath
			Suburban Hospit			Bethesda			tgomery
	Funeral		5. Social Security Number 6. S 007-10-8612	00=1		Year If Under 24 Hr Days Hours Min	8. Date of Birt (Month, Day	y_Year)	nthplace (State or Foreign ountry)
ļ,	Director		Usual Residence of Decedent	X 00	113.		March 1	7, 1910 M	aine
	land ow		10a. State 10b. County	10c. City, Tow	vn or Location				10d. Inside City Limits
	Man	to	Maryland Monto	omery	Rockville				1 ☐ Yes 2 ☐ No
	r 288	Irec	10e. Street and Number	, =	10f. Zip Co	ode		10g. Citizen of What C	country?
	h with	Funeral Director	12006 Ashley Dri	ve	208	352		USA	
	deat	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Deceden	t of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No-	- 14. Race - Arr Black, Wh	
9	or fit	F	1 ☐ Never Married 2 ☐ Married	1 X Yes 2 □ No	1 ☐ Yes 2 ☑		no moun, oto.,	C-noit.	
8	ure!,	d by	3 🙀 Widowed 4 □ Divorced	Year or Dates: 1941-48				V1	hite
21215-0036	within 72 hours after death with the Maryland sne. then "naturel", or iteme 23e or 28e-f ehow he Madical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra		i. Decedent's Usual C (Give kind of work of life. DO NOT use)	done during most of we	orking	16b. Kind of Busines	s/Industry
72	withii	μď	Elementary/Secondary (0-12)	College (1-4or 5+)		idget Analy	/st	Departmen	t of
0	filed Hygi other		17. Father's Name (First, Middle, Last)					Interior Maiden Sumame)	
lan	id be ental ked c	To Be	Montford Elmer Pa	ntten		Jose	ephine M.	Jackson	
ary	shound M	-	19a. Informant's Name/Relationship (Type, Print) 198	b. Mailing Address (S	itreet and Number or F	iural Route Numbe	er, City or Town, State,	Zip Code)
Ž	alth a 27 h		Louise E. Patten/	Daughter 1	119 Briggs	Chaney Ro	oad, Silv	er Spring,	MD 20905
ore,	of He of He item		20a. Method of Disposition	20b. Place o	of Disposition (Name ory, crematory or other	of	Date	20c. Location - City of	
Ĕ	Page nent nnt: if ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	Washington	· · · A	3	Adelphi, M	aryland
Baltimore, Maryland	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or iteme 23e or 28a-f ehow eny injury or other traumatic event, the Madical Examinar must be multiled at 80cc.		21. Signature of Funeral Service Licer	1500	Francis	ddress of Facility ins		Home Inc.	
<u> </u>	82559		your you	estuly	500 Univ	ersity Blv	d, W, Si	lver Sprin	g, MD 20901
П			234. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do one cause on each line.	not enter the mode of	of dying, such as cardia	ac or respiratory ar	rest,	Approximate Interval Between
Loa	Physician		Immediate Cause (Final disease or condition	a Acute Renal Fai	lure				Onset and Death 4 Davs
	/Medical Examiner		resulting in death)	Due to (or as a consequence			-		
п	Examine:	_	Sequentially list conditions,	b.Metastatic Blad	der Cancei	<u> </u>			6 Months
	ed sit	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	or):				
	eath certificate be executed ettending physicien and for use es the burial-transit	Examiner	that initiated events resulting in death) Last	c	of):				
68760,	sicier buris								
687	ficate physics the	Medical	•	d					
XO	nding use e		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date of de	alivery
$\mathbf{\omega}$	death le etter ed for u	Completed by Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 □Ectopic prega 5 □ Other (speci			Month	Day Year
o.	w requires that the death been signed by the ette should be detached for	hys	9 Unknown	9□ Unknown					
S, D	ns tha	Ϋ́	Part II. Other significant conditions of	ontributing to death but not resulting	in the underlying caus	se given in Part 1.	23e. Did to	obacco use contribute	to the cause of death?
ğ	The law requires that the ste has been signed by the baga 2 should be detache	- P	Metastatic Color	Cancer, Bactere	mia		1 🗆 Y	∕es 2⊡No XIÑIF	robably 4 Unknown
၁၁	law re as be 2 sho	ple	×				24a. Was		utopsy findings available
Ě	The ate ha	ĕ						rmed? death?	completion of cause of s 2 No
ita	Physicien: r this certificated director, is	Be (25. Was case referred to medical examiner?			26. Place of De	eath (Check only o		
×	hysic his co	ုင္	1 ☐ Yes 2 ☐ No	Hospital: 1 ☑ Inpatient 2 ☐ ER/O			Home 5 ☐ Resid	dence 6 □Other (Sp	ecify)
n C	ing P	ö	27. Manner of Death 1 → Natural 5 → Pending	(Month, Day Year)		Injury at Work?	28d. Describe h	low injury occurred	
Sic	Attending or death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be		М	1 Yes 2 No	006 1 6		
Division of Vital Record	or Ar	Certification;	4 Homicide determined	28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, o	ffice	City or Tow	Street and Number or F vn. State)	Rural Houte Number,
_	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	-	29a. Certifier 1 X Cartifying Ph	ysician: To the best of my knowledg	e, death occurred at	the time, date and place	e, and due to the	cause(s) and manner	s stated
	• Hos 24 h • Fur letely	edical		niner: On the basis of examination are and manner stated.	nd/or investigation, in	my opinion, death occ	urred at the time,	date and place, and du	e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	e de la companya del companya de la companya del companya de la co	1	icense number		29d. Date signed (Mor	
	10+1		1 Jeorge	- 2020x -	D.	43083		August 1	6, 2006
	1		30. Name and address of person who						
_			George A. Sotos	The state of the s	al Center	Drive, #3	00, Rocky	ville, MD 2	20850
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signature	A 10 0				
	Registr	ar	AUG 18 20	006 Barrey Jr	A TOWN THE THE PARTY OF THE PAR				

S116106 0120

Patter, Lloyd E.

			For Stata Registrar	State of Ma	aryland		artment of I		and Me		giene ,	2006	28181
			Decedent's Name (First, Middle,	Last)						2. Date of Dea	ath	Vasa	3. Time of Death
	Physici /Medic		WILLIAM	JOSEPH	PRI	NCE				AUGUST	18	2006	7:48 A M
×	Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, Town,		of Death		4c. C	ounty of Death	
			1001 Rockville				Rockv					lontgome	
	Funeral		5. Social Security Number 041-24-3503	6. Sex 7. Ag 11⊠M 2□F	pe (In yrs. las 73	t birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birtl (Month, Day	h v, Year)	9. Birth	place (State or Foreign intry)
	Director		Usual Residence of Decedent		- 75					Nov. 19	193	2 Conr	necticut
	yland		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Mar -	to	Md. Monte	gomery	Ro	ckvil	le						1⊠Yes 2□No
	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f ehow he Madical Examiner must be mullied at	Director	10e. Street and Number	D'1 #11	1407		10f. Zip Code	20052	,		10g. Citize	on of What Cou	intry?
	23a		1001 Rockville		L407			20852				ted Sta	
	er des	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	105		Was Decedent of f Yes, specify Cut	Hispanic Orig an, Mexican	gin? (Spec i, Puerto P	ofy Yes or No- lican, etc.)	. 14	I. Race - Ameri Black, White	
36	rs aft	by F	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 Yes 2 1 If Yes, Give Year or Dates:	195		1□Yes 2XNo	Specify:			S	Specify:	White
Ş	2 hou	bed	15. Decedent'	s Education		16a. Deced	dent's Usual Occu	pation			16b. Kind	d of Business/ir	ndustry
215	hin 7.	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of work done DO NOT use retire	during most ad)	t or workin	g			
2	od wit	Con	12	2		Mai	l Carrie						al Service
nd	d oth	Be	17. Father's Name (First, Middle, L							(First, Middle,	_	u <i>ma</i> m <i>e)</i>	
<u>Ş</u>	d Men marke	욘	Frederick F. 19a. Informant's Name/Relationsh	Prince		406 84-35	ng Address (Stree	Edr		- 4	ller	F C1-1- 7	'- O- d-1
Maryland 21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23a or 28a-f show many injury or other traumatic event, the Madical Examiliar must be nutified at once.		Dorothy E. Pr				Rockvil				-		
ē,	Heal Heal		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name of natory or other pla	2001	Da	ite	20c. Loca	ation - City or T	own, State
Baltimore,	Page 1	j	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp				lle Ceme	· I	8/2	3/06	Lay	tonsvil	lle, Md.
ati	partm porta y inju		21. Signature of Funeral Service L	icensee		22	Name and Addr Muriel H	ess of Facility	y Ser F	uneral	Home		
<u>m</u>	88 5 8		muriel	H. Ba	when		P. O. B						20882
			23a: Part1. Enter the disease, or c shock, or heart failure. List of	complications that caused only one cause on each li	d the death. ine.	Do not ent	er the mode of dy	ing, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	GAS	STRIC	CANCE	R						Onset and Death 4 Months
1	/Medical Examiner		resulting in death)	Due to (or as	a conseque	nce of):		-					
	12:	-	Sequentially list conditions,	b. Due to (or as	B CONSIDER	nten offr							
=	ited Insit	nin	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury										
a,	execting and ital-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a conseque	nce of):							_
8 60	The law requires that the death certifica e be executed as been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai		d									
ဖ	ing ph as th	Med	IF FEMALE:	1							-1		
Box	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal d	eath 3	Ectopic pregnanc	Э			23	d. Date of deliv	very Day Year
0	that the death certific ed by the attending p detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of dear	th 5L	Other (specify)						,
٥.	that the sed by detail		Part II. Other significant condition	ns contributing to death b	out not resulti	ing in the u	nderlying cause g	ven in Part I.		23e. Did to	bacco use	e contribute to	the cause of death?
g	quires n signe	d by								1 🗆 Y	es 2)	No 3□Pro	bably 4 □Unknown
Ö	aw requir ts been si 2 should	Completed								24a. Was	an	24b. Were aut	opsy findings available ompletion of cause of
E	hysicien: The lav his certificete has I director, page 2	autops perform 1 Yes 2									med?	death?	
<u>ta</u>		Bec	25. Was case referred to medical examiner?					26. Place	of Death	(Check only or			
×	hysic his ce Il dire	၉	1 ☐ Yes 2 No	Hospital: 1 Inpatie		VOutpatier	I 3 DOA		rsing Hom	e 5 AResid	lence 6	□Other (Speci	fy)
n c	ing P	on:	27. Magner of Death 1 Natural 5 ☐ Pending		ay Year) 2	8b. Time o Injury	We			8d. Describe h	ow injury	occurred	
Division of Vital Records,	Attending Physicien: Ir death. ector: After this certific by the funeral director.	cat	2 Accident investig 3 Suicide 6 Could n	ot be Zee Place of In	iury - At hom	e farm str	eet, factory, office]Yes 2 1		8f Location /S	treet and	Number or Bur	ral Route Number.
≦	atter Dire	Certification;	4 Homicide determine	building, et	tc. (Specify)	o, iaiii, sti	eet, ractory, office			City or Tow			a robio rvanisor,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 12 Certifying	Physician: To the best	of my knowle	edge, deat	occurred at the t	ime, date an	d place, a	nd due to the d	cause(s) a	nd manner as	stated.
	the Ho in 24 the Fu ipletel	edicai	one)	xeminar: On the basis of and manner st	ated.	n and/or in			tn occurre				
\	To the within 2 To the complet	Σ	29b. Signature and title of pertitier	70 D	7			se number 0610	00			signed (Month,	
•	10+1		faul of	rame				0010	05		TV.G.	10/20	06
	V -		30. Name/and address of person v PAUL THAMBI,				Print) CENTER I	RIVE,	ROC	KVILLE	, MD.	2085	50
	Sta	ite	31. Date filed (Month, Day, Year)	22 Poniete	rade Signatur	70		-		-,			
	Registr	ar	AUG 21	2006 Maga	s Signatur	A	94/2)						

			1 = For Stete Registra@MEND#29dpcm	State of I MD8/31/06,BM	Marylan W,McCo	d / Depa <i>Cei</i>	artment of H	lealth and M Death		giene2 0	06	28182
	Physici /Medio		1. Decedent's Name (First, Middle, Margaret B. Po	etkof					2. Date of Deamonth August	Day	Year 2006	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, Doctors Community				4b. City, Town, o Lanham	r Location of Death				orge's
	Funeral Director		578-36-7692	7. Sex 7. 1	-	last birthday) 34 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt Month, Da Feb. 28	, 1922	9. Birthpl Count Virg	lace (State or Foreign http) Sinia
e+	Aaryland f ehow	or	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	George's		y, Town or Lo					10	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
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1215-0		Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		or 5+)	16a. Deced (Give life. I Homen		oation during most of worl d)	king	16b. Kind of B		lustry
and 2	nit. Pages 1 and 2 should be filed within ordinated to Health and Mental Hygiene. ordinit: if item 27 is marked other than injury or other traumatic event, the M	Be	17. Father's Name (First, Middle, La		. ¬	Baird	IANCI	18. Mother's Nam			18)	Goodman
+/k	id 2 should lih and Men 27 ie marke traumatic	2	19a. Informant's Name/Relationshi Benjamin Petkof					and Number or Ru	ral Route Numbe			
nore,	permit. Pages 1 and. Department of Health Important: If Item 27 any Injury or other tr once.		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			Li Place of Disponentery, crem	sition (Name of natory or other place		Date	20c. Location -	City or Tov	wn, State
Baltimore	permit. P Departme Importan any Injur		21. Signature of Turberal Service Li		, low	_						land 20705
	Physician		23a. Part1. Ent in e disease, or c shock, leart failure. List of Immediate Cause (Final disease or condition resulting in death)	omplications that cau nly one cause on eac a	sed the death	h. Do not ent	er the mode of dyir	ephalu	or respiratory ar	rest,	raly	Approximate Interval Between Onset and Death
8760,	Medical Examiner physicien end the pridal-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a conseq	espi uence of):	ration, truch	ve lur	g dis	ease		
P.O. Box 68760	the death certifical / the ettending phy ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pyegnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		n 2 ☐ Feta it at time of d	Ideath 3□	Ectopic pregnancy Other (specify)	1			te of deliver	ory Day Year
	requires thet the di wen signed by the hould be detached	ρ	Part II. Other significant condition	s contributing to deat	th but not res	ulting in the ur	nderlying cause giv	ven in Part I.	V	18		ne cause of death? ably 4 Dunknown
l Reco	The law ate hes t page 2 s	Completed							24a. Was autop perfo 1 Yes	an 24b.	Were autop prior to con death? 1 Yes	psy findings available inpletion of cause of
Division of Vital Records,	ing Physicien: Th n. After this certificate funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	28a. Date of	njury	ER/Outpatien		4 U Nursing H	ome 5 Resid			ı)
ivision	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	Certification;	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	tion	Day Year) Injury - At ho, etc. (Specif	Injury ome, farm, str		rk? Yes 2 □ No	28f. Location (S City or Tox		er or Rural	l Route Number,
ā	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		(Check only 2 Medical E.	Physicien: To the be	est of my kno	wiedge, death	occurred at the til	me, date and place	and due to the	cause(s) and ma	inner as sta	ated.
	To the within 2 To the complet	Medical	one) 29b. Signature and title of certifier	and manner		ND	29c. Licens	DIANG	/ /	29d. Date signe		1
	, ~		30. Name and address of person w	ho completed cause	of death (Item	n 23a) (Type,	Print) 8 GOOD	LUCKR	di, Cai	nham,	mD.	, 20707
	Sta Registi		31. Date filed (Month, Day, Year) AUG 2 1	2006 32 Reg	pistrar's Signa	ture (pa	well?		,			

Physician /Medical Examiner 44a. Examiner 538 or 288-1 enough of the product of t	ie. Street and Number 3526 Twin Br . Marital Status 1 Never Married 2 1 Nover 3 Widowed 4 Divord 15. Decec	Pace ion, give street and n nches Driv 6. Sex 1/2 M 2 F ionty iontgomery 12. Was De Armed F 1 12/9s 11/2/9s	7. Age (In yrs	y, Town or Loc Silver S. 13. W ff	Silve If Under 1) Months C cation Spring 10f. Zip Cc 209	ays Hours	ing er 24 Hrs.	2. Date of Di Month Augus 8. Date of Bi (Month, D) June 2	Day t 18, 4c. (Mont 9. Bir	gomery thplace (State or Foreigontry) orth Caroli 10d. Inside City Limit 1 \(\text{Yes} \) 2\(\overline{\pi} \) N
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mportal 21	1. Signature of Funeral Serv	ce Licensee						Tuneral W, Si			, MD 20901
ansit Ca Ca Ca Ca Ca Ca	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last	b. Coror	o (or as a consequence of (or	eroscle	erosis						
We as	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	utcome of pregna birth 2 □ Fetal gnant at time of de nown	Ideath 3⊡I	Ectopic pregr Other (speci			99	23	3d. Date of de Month	olivery Day Year
an signed build be deta	art II. Other significant cond	itions contributing to	death but not res	ulting in the un	nderlying caus	se given in Par	rt I.				o the cause of death?
age 2								1 ☐ Yes	opsy ormed? 2 No	prior to death?	utopsy findings availab completion of cause of s 2 \(\square\) No
After this funeral dii		Hospital: 1 [28a. Date (Mostigation ld not be	Inpatient 2 e of Injury nth, Day Year)	28b. Time of Injury	28c.	Other: 4 Injury at Work? 1 Yes 2	Nursing Ho	me 5 X Res 28d. Describe	idence 6 how injury	occurred	
29	4 Homicide deta	rmined 289. Plac	ce of Injury - At ho ding, etc. (Specify ne best of my kno basis of examina	y) wledge, death	occurred at t	he time, date	and place,	City or To	own, State)	and manner a	s stated.
## du 29	one) 9b. Signature and title of cert	and ma	nner stated.	23a) (Type, F	29c. L	Cense number	y Y U		29d. Date Au	signed (Moni	th, Day, Year) .8, 2006 pring, MD 20

06-06346 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Toni Ann Perron 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day August 24, 2006 1725 hrs **Medical Examiner** Ann 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Montgomery Gaithersburg 149 Watkins Mill Road #4A 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday **Funeral** Foreign Washington Months Days Hours Director 10/12/1952 53 Yrs 212-64-5222 1 M 2 X F DC Usual Residence of Decedent 10d. Inside City Limits 10c City Town or Location iny 10a State 1 X Yes 2 No or items 23a or 28a-f show must be notified at once. Gaithersburg Maryland Montgomery death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code United States 149 Watkins Mill Road #4A Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 8lack or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White etc. 1 Never Married 2 Married Yes 2 X No If Yes, Give Year Yes 2 X No specify: Specify:White Widowed 4 X Divorced event, the Medical Examiner "natural", à or Dates 16a. Deceden's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) leted Baltimore, MD 21215-0036 emit Pages I and 2 should be filed within 72 hou upartment of Health and Mental Hygiene Important: If item 27 is marked other than "nat nigury or other traumatic event, the Medical Exa Elementary/Secondary (0-12) College (1-4 or 5+) Compl 2 Clerk Private 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Velia Daleo Be Anthony Sciamanna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Baldassano / Sister 62 Anna Court; Gaithersburg, Maryland 20877 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Burial 2 X Cremation 3 Removal from State 8/30/2006 Lincoln Crematory Brentwood, Maryland Donation 5 Other Specify 22. Name and Address of Facility
Simple Tribute
1040 Rockville 21 Signature of Funeral Lervice Licens Funeral and Cremation Center Pike; Rockville, Maryland 20852 23a/Part / Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure List only one cause on each line /Medical Death Tramadol intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED AMENDED attending physician item#23a.27.28a-f.perME.g859.9/15/06 TT es that the death certificate be Division of Vital Records, P.O. Box 68760, 23d, Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy se as the 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Dav Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a Was an Hospital or Attending Physician: The law requ prior to completion of cause of autopsy performed? death? Yes 2 2 No page 1 🗸 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Nursing Home 5 Residence 6 Other: Scene Inpatient 2 ER/Outpatient 3 DOA this 1 V Yes ဥ 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury After 27. Manner of Death 28a Date of Injury (Month, Day, Year) Certification Natural Yes 2 X No 5 Pending within 24 hours after death.

To the Funeral Director:
completely filled in by the f Fnd 8/24/2006 Fnd 5:18 pm unk 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 149 Watkins Mill Road Apt A Gaithersburg, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide (Specify) house determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifie 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 25, 2006

State

Registrar

Pameia Southall, MD 31. Date filed (Manth Gay, Year) 111 Penn Street, Baltimore, MD 21201

no completed cause of death (Item 23a) Assistant Medical Examiner

BABUSI

2006

			1 - For State Registrar Amend #17 pe	State of Ma er/FH 08-2							giene2 Reg. No.	006	28	185
	Dhysisi	20	1. Decedent's Name (First, Middle, Last)							2. Date of De. Month	ath Day	Year		of Death
	Physici /Medio		EVELYN	J	PARKE	R				AUGUS	T 18	3 200		20a ^M
1	Examin	er	4a. Facility Name (If not institution, give s				4b. City, Town	, or Location erick	of Death			ounty of Dea Freder		
			Frederick Memorial 5. Social Security Number 6. Sex		(In yrs. last b	irthday)	If Under 1 Yes		r 24 Hrs.	8. Date of Bird			thplace (State	or Foreign
	Funeral Director			M 2(X)F	82	Yrs.	Months Day		Min.	(Month, Da	y, Year)	C	nswick	•
			Usual Residence of Decedent							NOV 24	1723	DIU	IIISWICK	, 1110
	how		10a. State 10b. County		10c. City, To		cation						10d. Inside	-
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	or 20	Dire	10e. Street and Number				10f. Zip Code					n of What Co	ountry?	
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or itema 23a or 28a-f show appringury or other traumatic event, the Medical Examinar must be notified at ODGE.	by Funeral Director	11. Marital Status 1 Never Married 2 Amarried 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 XN If Yes, Give Year or Dates:			Vas Decedent o Yes, specify C □Yes 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\			lican, etc.)		Black, Whi		
ŏ	2 hou	ted	15. Decedent's Educ	ation	16	a. Deced	ent's Usual Occ	upation	-4 -6		16b. Kind	of Business	/Industry	
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land	lid be fill fental H rked oth	To Be	17. Father's Name (First, Middle, Last) Homer C. Parker	Walter Jew	wel Cro	w1				(First, Middle,		imame)		
Maryland 21215-0036	nd 2 shoulth and A 27 ie ma		19a. Informant's Name/Relationship (Type Homer C. Parker, H				g Address (Stre Virts					own, State, 1755	Zip Code)	
Baltimore,	ages 1 a int of Hea t: if item y or othe		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	cemet	егу, сгеп	sition (Name of patory or other p		Da rdens			•	Town, State	
Ħ	artme ortan injur	1	21. Sign up Fu Fra Service License	10/ 11/1.	, Kesti	22	Name and Ad	ress of Facil	lity			.IICK,	тш	
ä	Deparimpo impo any ir		Barbara A. Wil	Many Mon	ner		ohn T.					k MD	21716	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused	the death. Do	not ente	or the mode of o	lying, such a	s cardiac or	respiratory a	rrest,		Approxim Interval B	ate
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence	e of):								
	icate be executed physician and the burial-transit	хап	that initiated events cresulting in death) Last	Due to (or as a	a consequence	e of):							-	
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Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome			-				230	d. Date of de	livery	
m	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregna Other (specify)				1	Month	Day	Year
P.O.	that the de ned by the a detached f	hys	9 🗆 Unknown	9□ Unknown										
	igned be del	by	Part II. Dther significant conditions con	tributing to death bu	,			given in Part	t I.				o the cause o	
ord	w requir been si should I	Completed	Cososary	arreny	121	SPCI	SE			1	Yes 2.27		robably 4 [
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of	Phys this aldir	7	1 ☐ Yes 2 ☐ No ☐ ☐ 27. Manner of Death	28a. Date of Injur		Outpatien . Time of	3 DOA			e 5 Resi			ecify)	
u	ding After funer	ion	1 Natural 5 ☐ Pending	(Month, Day	Year)	Injury		ijury at Vork? □ Yes 2 □	,	BO. Describe	now inquity c	rccurred		
Division of Vital Records,	Hospitel or Attending Physician: 34 hours after death. Funeral Director: After this certificately filled in by the funeral director, tely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc		farm, stre				Bf. Location (City or To		Vumber or R	Tural Route No	ımber.
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	29a. Certifier (Check only one) 40 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												9 (S)
	To the within 2 To the complex	Me	29b. Signature and title of certifier				l l	ense number					th, Day, Year,	
	->-0) De				Do	060	417		81	110/	06	
	5		30. Name and ad ress of person who co	mpleted cause of de	eath (Item 23a) (Туре,	Print)				- '			
				D, 65	C. Th	rom	Do Print) Do	msev	1 DV	. th	ederi	CIC.	MB 2	1702
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1	/Medi	cal	4a. Facility Name (If not institution, give	10 E		4b Cib	Town as	Location of Dea	August		County of Deal	
1	Exami	ıer	SHABY GROVE		HOSPOR	l D	ckvi	lle	uı	40.	Montgo	
	Funeral Director		5. Social Security Number 6. Se 219-11-7288				er 1 Year s Days	If Under 24 Hrs Hours Min		v, Year)	Co	inplace (State or Foreign ountry) eru
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation						10d. Inside City Limits
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036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Itams 23a or 28a-1 show amy injury or other treumatic event, the Medical Evarrinar must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:				spanic Origin? (Sn. Mexican, Puer Specify: Pe	Specify Yes or No- to Rican, etc.)		14 Race - Ame Black, White Specify:	
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Baltimore, Maryland 21215-0036	uld be filed Aental Hygii rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last) Ricardo Quiroz		Hain	icen	ance		me <i>(First, Middl</i> e, aria Zu		Sumame)	
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٢	/Medical Examiner		resulting in death)	Due to (or as a consec								
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P.O. Box	the death certificate be executed y the attending physicien and tched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	aldeath 3□	Ectopic Other (s	pregnancy specify)			4	23d. Date of deli Month	very Day Year
	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions con	ntributing to death but not res			cause give	n in Part I.		baccou		the cause of death?
Division of Vital Records,	Physicien: The law requires that the this certificete has been signed by the diffector, page 2 should be detached.	Completed	Hypelipi Denis	<u> </u>					24a. Was a autops perform	y med2	24b. Were au prior to death?	topsy findings available completion of cause of
Ita	sien: artifice ctor, p	BeC	25. Was case referred to medical examiner?					26. Place of De	1 ☐ Yes	2 /25 /No	10105	2)2(No
ot V	Physic this co	은	1 □ Yes 2 No		ER/Outpatien			4 🗀 Nursing r	lome 5 ☐ Reside	ence 6	3 □Other (Spec	ufy)
00	ding fin.	tlon:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	м	28c. Injury Work	at ? es 2 □ No	28d. Describe ho	ow injur	y occurred	
Divisi	el or Atten after deat I Director: d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre			63 2 110	28f. Location (St City or Town			ral Route Number,
	To the Hospitel or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) Certifying Physical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred vestigatio	d at the time n, in my op	e, date and place inion, death occu	a, and due to the carred at the time, d	ause(s) ate and	and manner as place, and due	stated. to the cause(s)
	To ti Withii To ti	Σ	29b. Signature and title of certifier) ^		29	c. License	number	2	9d. Dat	e signed (Month	i, Day, Year)
3	3		A int	las godo	MO		D64	1444		Aug	not 15	12006
	~		30. Name and address of person who co				N 8.	/				
	Sta	te	ARUIT DASGU. 31. Date filed (Month, Day, Year)	32 Registrar's Signa			UKI	ve, C	FITHER	Cl BC	ARG, R	10 20810
197-	Registr		AUG 18 20	32 Registrar's Signa	ture doe	SALL!						

DHMH 17 Rev 1/2001

			1 - For State Registrar	State o	f Marylaı	nd / Depa <i>Ce</i>	artment rtificate	t of H	ealth a Death	and M	lental Hyg	giene	20	06	2818	_
			1. Decedent's Name (First, Middle, Las	t)							2. Date of Dea				3. Time of Death	-
	Physici /Medi		Emil Alexander	Romagn	oli						August	08,	, 20	006	5:51 p ^M	
	Examir		4a. Facility Name (If not institution, give		n <i>ber)</i>		4b. City, 1	Town, or	Location o	of Death		4c. (County of	Death		
			Suburban Hospita					hesd					lont			_
	Funeral		5. Social Security Number 6. Se 104-34-8519	9X (2XM 2 □ F	7. Age (In yrs		If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day	v. Year)	1	9. Birthpl Count	ace (State or Foreign try) York	
	Director		Usual Residence of Decedent			62 Yrs.					Jan. 01	1, 15	44	New	YORK	_
	yland now		10a. State 10b. County		10c. C	ity, Town or Lo	ocation			-				10	d. Inside City Limits	-
	B-f-el	tor	Maryland Montgon	nery	F	Rockvil	.1e								1 XYes 2 ☐ No	
	or 28	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of Wh	at Count	try?	
	23a	ai	15 Hollyberry Co	ırt			2	0852				Uni	ted	Stat	es	
	teme teme	nue	11. Marital Status	Armed For		J.S. 13.	Was Decede	ent of His	spanic Origin, Mexican	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	. 1		America White, e	an Indian, etc.	
36	s afte	by Fi	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 🖾 Yes If Yes, Giv			1□Yes 2		Specify:			- 1	Specify. W			
3	hour	ed t	15. Decedent's Ed		ates:V Teri		dent's Usua	LOccupa	tion				d of Busi			_
<u>.</u>	tiled within 72 hours after death with the Maryland Hygiene. Uther then "natural", or Iteme 23a or 28a-f ehow ent, the Madical Examinat must be nailfied at	Completed	(Specify only highest gra	de completed)	4	(Give	kind of work	k done di	uring most	of worki	ng	TOD. KIII	d of busi	11622/11/0	ustry	
717	filed withi Hygiene. Ither then	E	Elementary/Secondary (0-12)	College (1 5+	-40r 5+)	Direc	tor o	f Go	vern	ient	Affairs	s M	linin	ıg		
<u> </u>	m U E	Bec	17. Father's Name (First, Middle, Last)								(First, Middle,		Sumame)			
<u>ā</u>	Venta Menta Irked	2	Emil Romagnoli						Mar	у А.	Alexar	nder				
Maryland 21215-0036	2 should be filed v n and Mental Hygie le marked other reumatic event, III	. 3	19a. Informant's Name/Relationship (7	ype, Print)		19b. Maili	ng Address	(Street a	nd Numbe	r or Rura	l Route Numbe	r, City or	Town, St	ate, Zip	Code)	
≥	and ealth m 27	0 1	Douglas Romagnol	Li / Son		and the same of the same of				-	ckville	e, Ma	ry1a	nd 2	20852	_
9	I I I I	- 46	20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □	Removal from S	State 20b.	Place of Dispo cemetery, crea	sition (Nam matory or oti	e of her place)	D	ate	20c. Loc	ation - C	ity or Tov	wn, State	
Ē	Paris Paris	1 3	4 □ Donation 5 □ Other (Specify			Linco									[aryland	
saltimore,	permit. Pages 1 and 2 should be Deperment of Health and Menta Importent: If them 27 Is marked any injury or other traumatic as once.		21. Signature of Funeral Service Licen.	S00		Si	nple n	Address	of Facility	uner	al and	Crem	atio	n Ce	enter	
_	70 5 4 0		4.		,	10	40 Roc	ckvi.	lle P	ike;	Rockvi	lle,	Mar	ylar	id 20852	
			23a. Part I. Enter the disease, or composition, or heart failure. Listion y	one cause on e	aused the dea ach line.	th. Do not ent	ter the mode	of dying	, such as	cardiac o	r respiratory arr	rest,			Approximate Interval Between Onset and Death	
y. i	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Sudder	n Cardi	ac Dea	th								4 minutes	
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):										
		-	Sequentially list conditions, if any, leading to immediate	Conges	stive H		ailure	е							3 months	_
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury												2 .1	
	sicien end	xar	that initiated events resulting in death) Last	c. Mitral Due to (or as a consec		OII							-	3 months	_
8/00,	ate be executed hysicien end the burial-transit	cali		_{d.} Corona	arv Art	erv Di	sease								6 years	
9	0 0	7.0		u											, , , ,	
ğ	es dir	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			7=					23	3d. Date	of deliver	у	
	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregna	inth 2 ☐ Feta ant at time of o]Ectopic pre] Other (spe						Month	n [Day Year	
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Ś	requires that the een signed by the hould be detached	P	Part II. Other significant conditions co	entributing to de	ath but not res	sulting in the u	nderlying ca	use give	n in Part I.		23e. Did to	bacco us	e contrib	ute to the	cause of death?	
ecords	v requir	D.	Sleep Apnea								1 🗆 Y	es 2 🛚	No 3	☐ Proba	bly 4 ∐Unknown	_
ပ္	a a s c	pe									24a. Was a		24b. We	re autop	sy findings available	
<u> </u>	That are	Compl									perform	med?	dea	ath?	2□ No	
Z Z	Physician: this certific al director.	Be	25. Was case referred to medical examiner?	11				T .		of Death	Check only or	10)				
5	Physic this c	၉	1 1 195 2 2 1 NO			ER/Outpatier			4 🔲 Nui		ne 5 🗆 Resid					
	After	ion:	27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date o (Monti	of Injury h, Day Year)	28b. Time of Injury		lc. Injury Work			28d. Describe h	ow injury	occurred			
UNISION	Attending r death.	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	29 a Place	of Injury - At h	omo form etc	M		es 2⊡h	-	8f. Location (S	*	A1	0 1	G 11 1	-
$\frac{2}{5}$	o ele	ertif	4 Homicide determined	buildir	ig, etc. (Speci	fy)	eer, ractory,	Office		-	City or Town		Number	or Hurai	House Number,	
	spital	aiC	29a Certifier 1 X Certifying Phy	relicians To the	best of my kni	owledge, death	'i useumud a	t the time	a. date and	d claes, s	ind due to the a	ausels) a	nd mann	ar as sta	16.1	
	P Ho	g e	(Check only 2 Medical Exam	iner: On the ba and mann	isis of examina	ation and/or in	vestigation,	in my opi	nion, deat	h occurre	d at the time, d	late and p	olace, and	d due to	the cause(s)	
	To the the	Σ	29b. Signature and title of certifier	00	100	2	29c.	License	number		2	29d. Date	signed (Month, D	ay, Year)	-
1.6	VA S		· alli	1/	Lund.	BL		0 -	114.	7		0	8/0	9/0	6	
75	D W		30. Name and address of person who c	ompleted cause	e of death file	m 23a) (Type,	Print)		-	-				. / 0		-
_	1		Allen A. Nimetz,	M.D.	5530 W	iscons	in Ave	nue	Che	vy C	hase, M	aryl	and	2081	7	
	Sta		31. Date filed (Month, Day, Year)		gistrar's Sign	ature	parte					-	-			
	Registr	ar	AUG 18:	ZUUD 🥻	The said	15 19	13-50									

06-06289

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Gussie Rottenberg 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) Date of Death Physician/ Month Day August 22, 2006 1919 hrs Rottenberg Gussie Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Montgomery General Hospital Olney 8. Date of 8irth (MM/DD/YYYY) 9. 8irthplace (State or If Under 1 Year If Under 24Hrs 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreign Country,IL Months 3/13/1923 83 322-16-6409 2 X F Director Yrs М Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Silver Spring 1 X Yes 2 No MD Montgomery 28a-f show hours after death with the Maryland Director 10f. Zip Code 10g Citizen of What Country? 23a or 28a-f notified at o 10e. Street and Number e World Blvd. 12. Was Decedent Ever in U.S United States 20906 3330 North Leisure 14. Race - American Indian. 8lack. . Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11 Marital Status White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 1 Yes 2 X No White 1 Yes 2 No specify w Widowed If Yes, Give Year 27 is marked other than "natural", omatic event, the Medical Examiner Divorced 3 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of 8usiness/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 721 nent of Health and Mental Hygiene Own Home Homemaker Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) Anna Goldenson 17. Father's Name (First, Middle, Last) Harry Rossof Be traumatic event, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barhara Bernstein - Daught 20a Method of Disposition Chestnut Lane Rowie MD 20715 it: If item 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 X Cremation 3 X Removal from State Important: injury or oth 8/29/06 Falls Church VA **Department** National Crematory Donation 5 Other Specify: - Tra Service License 22. Name and Address of Facility Edward Sagel Funeral Direction 21. Signature of E 1091 Rockville Pike Rockville MD 20852 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X UNPENDED AMENDED item#23a,PII,27,perME,g860, 10/5/06 TT attending physician or use as the burial Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Dav Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 V No 9 Unknown Unknown 23e Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Division of Vital Records, P.O. ð Yes 2 No 3 Probably 4 Unknown Aortic stenosis; tachy-brady syndrome with pacemaker Completed 24b Were autopsy findings available 24a. Was an this certificate has been I director, page 2 should placement: diabetes mellitus autopsy performed? prior to completion of cause of death? ✔ Yes 2 No 2 No 1 🗸 Yes 26 Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death 25. Was case referred to medical Be examiner? Other₄ Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 Nursing Home 5 Residence 6 Other 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury Certification: within 24 hours after usam.

To the Funeral Director: A 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 23, 2006 O.C.M.E. MD 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, gistrar's Signatur

Registrar DHMH 17 Rev 1/2001

OCMF 2006

State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No () () 6 Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2006 7:30 Α August Runkles Henry Ρ. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Mt. Airy Carrol1 Lorien Mt. Airy If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours XXM 2□F Yrs. 18,1918 May Maryland Director 213-01-5630 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: if Item 27 is marked other then "natural", or Itema 23a or 28a-f show ury or other traumatic event, the Medical Examinating the notified at Maryland | Carroll 1 XYes 2 No Mt. Airy 10g. Citizen of What Country? USA 10f. Zip Code 10e. Street and Number 21771 Ճ 1313 South Main Street Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 25 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mattie B. Wilson 2 Marion V. Runkles, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1313 S. Main Street, Mt. Airy, MD 21771 Clarice A. Runkles/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or once. Frederick Crematory 8/23/2006 Frederick, MD 21702 22. Name and Address of Facility Stauffer Funeral Home, PA B E. Ridgeville Blvd, Mt. Airy, MD 21771 1 23a. Party Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4⊡Pregnant at time ol death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š t Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b autopsy 1 ☐ Yes 2 ☐ No 2 No Director: After this certific I in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) determined 4 | Homicide 24 hours a 29a. Certifier 1 Centifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c 1 icense number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2006 005813 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stoner 1:16u Date filed (Month, Day, Year) gistrar's Signature State AUG 28 Registrar

		a.	For State Registrar	State of M	aryland		artment of rtificate o				giene Reg. No. 2	006	28190
	Physici	an	Decedent's Name (First, Middle	•	-					2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic	al	David L.	Sheph			4b. City, Town	or Location	of Death	August		2006 nty of Death	5:00 A M
	Examir	ier	4a. Facility Name (If not institution, South River He			ation	Edgew		OI Death			ine Aru	ndel
	Funeral		5. Social Security Number 215–12–1850	6. Sex 7. A 1X M 2 F	ge (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Day		24 Hrs. Min.	8. Date of Birt (Month, Day Feb 22	h y, Year) 1921	9. Birthpl Count	ace (State or Foreign try) Land
١.	Director		Usual Residence of Decedent							ren 22	1741		
	Marylar f show	ō	MD Anne	Arundel	10c. City	, Town or Lo Loth						10	Od. Inside City Limits 1 ☐ Yes 2 ☐ No
	28e-	Director	10e. Street and Number	ALUIGEL		TOC.	10f. Zip Code)			10g. Citizen	of What Coun	try?
	th with	ai Di	5808 Greenock	Road			2071				U.S	.A.	
036	72 hours after death with the Maryland 'naturel', or Items 23s or 28e-1 ehow Jical Examiner must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Deceden Armed Forces ed 1\hbblee Yes 2 If Yes, Give Year or Dates:	? No WW		Was Decedent of If Yes, specify Co 1 ☐ Yes 2 ☑ N			cify Yes or No- Rican, etc.)	- 14. F E Spe	Race - America Black, White, e acify: Wh	
5-0	72 ho natur	eted	15. Decedent (Specify only highes	's Education t grade completed)		16a. Dece (Give	dent's Usual Occ kind of work do DO NOT use ret	cupation ne during mos	st of workin	ng	16b. Kind of	f Business/Ind	lustry
21215-0036	be filed within 72 ho ital Hygiene. id other than "netui event, ILE ME JIEA	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		niversit	_			Highe	er Educ	ation
nd 2	al Hygie 1 other vent, II	BeC	17. Father's Name (First, Middle, I							(First, Middle,			_
Maryland		2	William Owe		erd	10h Mailie	ng Address (Stre		sie	I Pouto Numbe		derlan	
	od 2 s lth ar 27 is r treu	K I	19a. Informant's Name/Relationsh Margaret Poole		wife)8 Green						C00e)
Baltimore,	iges 1 ar nt of Hea if item or other		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation	3 □Removal from State	e Ce	emetery, cre	nsition (Name of matory or other p	olace)		-2006		on - City or To	
ıltim	permit. Pages. Department of H Important: If its eny injury or of		*4 □ Donation 5 □ Other (St. 21. Signature of Funeral Service)	pecify)	Metr	-	in Cremato 2. Name and Ado	тy		-2000	ATEX	andria	, VA
Ba	Dep Imp		1 Kohn.	Jarah			Rausch	Funera	l Hor	me, PA	Owing	s, MD	20736
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each	d the death line.		er the mode of o	ying, such as VHN	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	ience of):	Hic Co	arch's	Va	sula	7 dise	ase	
L	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	s a consequ	ience of):		TV CCT C	7 - 0	2001			
,092	te be executed ysician and ne burial-transit	ical Exa	resulting in death) Last	Due to (or a	s a consequ	ience of):		-					
89			IF FEMALE:		-	-							
P.O. Box	The law requires that the death certifica the has been signed by the attending phoage 2 should be detached for use as it	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 🗌 Fetal	death 3	□Ectopic pregna □ Other (s <i>pecify)</i>					Date of delive Month	ry Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause given in Part I. 1 Yes 2 No 3 Probably													
Records,		Completed	Panoxyem	al Atri	'ay	Fibr	rillati	on.		24a. Was autop perfo 1 Yes	rmed?	prior to cor death?	osy findings available inpletion of cause of
Vital	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					. 1000	e of Death	(Check only o	ne)		
of V	Physicien: this certifican ral director,	은	1□Yes 2☑No	Hospital: 1 🗆 Inpa		ER/Outpatie	nt 3 DOA			me 5 🗆 Resid			′)
o uc	ding P. After t		27. Manner of Death 1 Natural 5 Pendin 2 Accident investig		jury ay Year)	28b. Time o Injury		njury at Vork? □Yes 2□		28d. Describe l	how injury oc	curred	
Division	I or Attendi after death. Director: A I in by the fu	Certification:	2 Accident Investig 3 Suicide 6 Could i 4 Homicide determ	not be 28e. Place of I	njury - At ho atc. (Specify	me, farm, st	reet, factory, offic	00	-	28f. Location (S City or Tox		ımber or Rura	l Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medicai C		g Physician: To the bes Examiner: On the basis and manner	of examinat								
)	To the within To the comple	Me	29b. Signature and title of certified	v. c.	m	ano	29c. Lice	ense number	653	3		gned (Month,	2006
50	10+1		30. Name and address of person 5851 -	who completed cause of Deale	death (Item	23a) (Type,	Print) G>	'AN'	c.	SUP	ANTA	mp	20757
ľ		ate rar	31. Date filed (Month, Day, Year)		tres Signa Classes		Spark	9					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006

	•	For State Registrar	•		Certifica	ate of De	eath	R	eg. No.	0 20	
		1. Decedent's Name (First, Middle, Las	it)					2. Date of Deat Month	th Day Ye	3. Time of	
Physicia /Medic		James Howard Sa	mple						15, 2006	6:45	р
Examin		4a. Facility Name (If not institution, give	street and number)		4b. Ci	-	cation of Death		4c. County of C		
		Montgomery Hospic					cville			gomery	
Funeral Director		5. Social Security Number 6. S 216-44-5588	ex 7. Age (/ ☑ M 2☐ F 59	In yrs. last bir	Yrs. Month		FUnder 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 31	, 1946 Wa	Birthplace (State of Country) Ishington	, [
≥ 8885	-	Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town	n or Location					10d. Inside C	itv Lim
oho a	5		gomery	•	Germant	own				1 ☐ Yes	
28a-1	Directo	10e. Street and Number	joinery			Zip Code			0g. Citizen of Wha	t Country?	
23a or 3		11105 Brink Road	ì		101.		876		-	JSA	
PE SI	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was De	cedent of Hisp pecify Cuban,	anic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc.	
lene. rihan "natural", or itame 23a or 28a-f ehow the Madical Examinar must be mulified at	þ	1 ☐ Never Married 2 🙀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			_	Specity:		Specifyhj	te	
hetu	Completed	15. Decedent's Ed (Specify only highest gra		16a.	Decedent's U (Give kind of	work done duri	on ing most of work		16b. Kind of Busin	ess/Industry	
Man	du du	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT	use retired)					
other t	S		1		Ma	nager	2. Mathada Nam	- (Circt Middle	Retail Maiden Sumame)	Food	
- 0	To Be	17. Father's Name (First, Middle, Last) John Virgil Sam				18			en Birch		
S S S S S S S S S S S S S S S S S S S		19a. Informant's Name/Relationship (Туре, Print)		-				r, City or Town, Sta		
27 l		Kathleen K. Samp	le/ Wife	1:	1105 Br	ink Ro	ad, Ger	mantown,	MD 20874	1	
Important: If item 27 is marked any injury or other traumatic events.		20a. Method of Disposition 1 ☐ Burial 2 ③Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		cemeter	f Disposition (f ry, crematory o olitan C	r other place)	Augu	st 19,	20c. Location - City lexandria		nia
in in		21. Signature of Funeral Service Licer	1500		Franc	and Address	c54 ins	Funeral	Home Inc		
EES		Kullekur /	Melles		500 τ	nivers	ity Blv	d, W, Si	lver Spri	ing, MD 2	209
		232 Part 1. Enter the disease, or dom shock, or heart failure. List only	plications that caused the	e death. Do	not enter the m	ode of dying,	such as cardiac	or respiratory arr	est,	Approxima Interval Be	te tween
sician		Immediate Cause (Final	, Metastatio		Small ('ell Lu	ng Canc	er		Onset and	Death
ledical		disease or condition resulting in death)	Due to (or as a			CII II	ng cane	CI			
aminer			b Chronic O	bstruc'	tive Pu	lmonar	y Disea:	se			
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c			,					
physicien and s the burial-transit	Examiner	Cause (Disease or injury that initiated events	C.								
en ar rial-t	EX	resulting in death) Last	Due to (or as a c	consequence	of):						
ysici	Ca	•	d		<u>-</u>						
ing ph e as th	Medical	15.551411.5							1		
attendir for use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		3 ∏Ectopio	pregnancy			23d. Date o	•	\/
e att	100	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at tir		5 Other				Month	Day	Year
signed by the a be detached f	Physician/	9 Unknown	3G GIRIOWI					1			-
gned se de	by F	Part II. Other significant conditions	ontributing to death but	not resulting i	n the underlyin	g cause given	in Part I.		bacco use contribu		
been si should I								XL Y	es 2 🗆 No 3 [Probably 4 🗆	Unkn
S C1	Completed							24a. Was a	an 24b. Wer	e autopsy findings r to completion of	avail
	E O							perfor 1 ☐ Yes	med? dea	th? Yes 2□ No	
certificate rector, pag	Bec	25. Was case referred to medical				2	6. Place of Dea	th (Check only or			
iis certifica director.	70 E	examiner? 1 ☐ Yes 2 ☐xNo	Hospital: 1 Inpatient	2 ER/O	utpatient 3	DOA Other:	4 Nursing H	ome 5 ☐ Resid	lence 6 🖾 Other (Specify) Host	pic
ter th		27. Manner of Death	28a. Date of Injury (Month, Day)	28b.	Time of Injury	28c. Injury a Work?	t	28d. Describe h	ow injury occurred		
r. Af	atic	1 SNatural 5 Pending 2 Accident investigatio	n		М		s 2 □ No				
Director: After this certification by the funeral director.	Certification;	3 Suicide 6 Could not be determined		y - At home, fa (Specify)	arm, street, fac	tory, office		28f. Location (S City or Tow	itreet and Number on, State)	or Rural Route Nur	nber,
within 24 nouts after death. To the Funeral Director: After completely filled in by the funer	edical C		nysician: To the best of miner: On the basis of e and manner state	xamination ar							s)
the mple	Med	29b. Signature and title of certifier	und mailler state			29c. License r	number		29d. Date signed (A	fonth, Day, Year)	
		Rejnthia W) Willias	no, I			58032			ust 200	6
)		30. Name and address of person who Cynthia William						ville, N			
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	Spark	2					

		1	For State Registrar	State of Marylan			t of Hea e of De			R	eg. N2 (006	28192
F	Physicia		1. Decedent's Name (First, Middle, Last)	1.5 chwe	e/				N	ate of Deat lonth	Day	Year 2006	3. Time of Death Z240 M
	/Medica Examine		4a. Facility Name (If not institution, give s		ماور		Town, or Lo	cation of De			7	unty of Death	11
	uneral rector		5. Social Security Number 6. Sex 289-18-7797	м 2 ^M F 7. Age (In yrs. I	last birthday) Yrs.	If Under Months		Under 24 H Hours Mi		ate of Birth fonth, Day,			ace (State or Foreign try) ucky
the Maryland	28a-f show	rector	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome 10e. Street and Number		y,TownorLo					1	0g. Citizen	10 of What Coun	od. Inside City Limits 1 ☐ Yes �� No try?
G KIKIS-UUSO filled within 72 hours after death with the Maryland Hygiene.	Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinar must be notified at once.	by Funeral Director	3310 N. Leisure V	Vorld Blvd, # 2. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	S. 13.			906 anic Origin? Mexican, Pu Specify:	(Specify \ erto Ricar	res or No- n, etc.)		USA Race - America Black, White, e	
Z I Z I 3-0050 od within 72 hours afl giene.	than "natura tre Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give life.	kind of wo DO NOT us	al Occupation rk done during retired) Special	ng most of v	working			of Business/Ind	
Maryland Z Id 2 should be filed Ith and Mental Hygi	narked other	To Be Co	17. Father's Name (First, Middle, Last) Willard R. Rath	Original Control			18	. Mother's N	Н.	Mari	Maiden Su e Luk	mame) DY	- Institute of the second
Te, Mar 1 and 2 sh Health and	tem 27 is m		19a. Informant's Name/Relationship (Typ. Linda J. Schweer/ 20a. Method of Disposition	Daughter		North	Shor			New M	arket	own, State, Zip MD 2: ion - City or To	1774
Baltimore, permit. Pages 1 at	important: if it		1 Surial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	Gate	e of Hea	aven Ce 2. Name an ranci	metery d Address o	f Facility Collin		s neral	Home	Inc.	, Maryland
Too,	lysicia ne bur	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only an Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq	yence of): uence of):		le of dying, s	such as card	fiac or res	piratory arr	est,		Approximate Interval Between Onset and Death
necolds, P.O. DOX 06 The law requires that the death certifical	igned by the attending ph be detached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₹ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3[⊒Ectopic pi ⊒ Other (sp					23d	I. Date of delive Month	Day Year
quires that	been signed b should be deta	ed by PI	Part II. Other significant conditions cor	tributing to death but not res	ulting in the u	underlying o	cause given	in Part I.		23e. Did to 1 □ Y	V		ne cause of death? ably 4 □Unknown
	page 2 sho	Complet							-	24a. Was a autops perfor 1 ☐ Yes	sy	prior to cor death?	psy findings available npletion of cause of 2 No
n or vital ng Physician: T	fter this c	on: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	o spital: 1 X Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatie	of a	Other: 28c. Injury at Work?		g Home		ence 6	Other (Specify	y)
DIVISION OF To the Hospital or Attending Phywithin 24 hours after death.	I Director: Aft d in by the fur	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, st	M treet, factor		s 2 No		ocation (S Dity or Tow		lumber or Rura	l Route Number,
ns Hospit	To the Funeral Dirac completely filted in by	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my knoner: On the basis of examina and manner stated.	owledge, dea ition and/or in	th occurred nvestigation	at the time, n, in my opin	date and place on, death of	ace, and o	the time, c	late and pl	ace, and due to	the cause(s)
1 de 1		W	29b. Signature and title certif	MMI			c. License n		24			igned (Month,	
		te	Stron 1 Hamifon 31 Date filed (Month Day Year)	mpleted cause of death (Iter	468	Print)	00 2	W	16	5+	Ball	twore	M-> 2128

State of Maryland / Department of Health and Mental Hygiene For #23a Part 1 Line B&C, 8/22/Obertificate of Deathper physician 2006 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician $\underline{\underline{A}}^{\mathsf{M}}$ Eugene Clair Strausbaugh 08/18/2006 9:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 10340 New Quay Road Worcester Ocean City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1√2 M 2□ F Hours Months Days 76 Yrs. Director 197-22-0119 07/23/1930 PA Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits ral, or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 🗶 No Directo Worcester Ocean City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code WIT 10340 New Quay Road 21842 USA Funeral deeth 12. Was Decedent Ever in U.S. Armed Forces? 1√D Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural" or than "natur. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintenance Supervisor Poultry Factory othert 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clair Strausbaugh Myrtle Sheffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 440 Stover Rd. Mifflinburg, PA 17844 Gregory Strausbaugh (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State Department of himportant: If its eny injury or of once. 1 ☐ Burial 2XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 08/21/2006 Frankford, DE 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Burbage Funeral Home 108 William Street Berlin, MD 21811 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): Antiny Disease disease or condition resulting in death) /Medical Examiner Coppl S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine ettending physician and for use as the burial-transit The law requires that the death certificate be executed E_{010} n = e n = Due to (or as a consequence of): that initiated events resulting in death) Last Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. P 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ۵ sign 1 be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 20 No 1 ☐ Yes 1 Yes 2 No director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 Accident Director: / 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide the Hospitel or 29a. Certifier Le certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Ambiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8/21/06 HU053714 30. Name and addr s of person who completed cause of death (Item 23a) (Type, Print) 10+1 Ne Jule 312 MATLONS 31. Date filed (Month, Day, Year) State AUG 2 2 Registrar

			1 - For State Registrar	State of Marylar		nent of Health and cate of Death	Mental Hygie	2000	28194
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last Anna 4a. Facility Name (If not institution, give	1: Zabetk		City, Town or Location of Dea	August	Day Year 21, 2006 4c. County of Deatl	
	Examir Funeral Director	ier	Mallard Bay 6 5. Social Security Number 6. Se	Care Cent	er	Cambridge nder 1 Year If Under 24 Ar	s. 8. Date of Birth (Month, Day, Ye	Dorche 9. Birth Co	ester hplace (State or Foreign untry)
	D	ctor	Usual Residence of Decedent 10a. State 10b. County MD Dorck	10c. ci	ty, Town or Location	Creek	001.43	77.5	10d. Inside City Limits
3	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f ehow adical Examinat must be notified at	Funeral Director	10e. Street and Number		0.Box 51	f. Zip Code 2/622 Decedent of Hispanic Origin? (Citizen of What Co	
215-0036	hours after d	by	1 ☐ Never Married 2 ☐ Married 3 12 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 🗆 Ye	ecedent of Hispanic Origin? (specify Cuban, Mexican, Pue as 2 No Specify:		Specify: B10	a, etc.
21215-	c * 3	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give kind o	Usual Occupation of work done during most of wid or with the order of	orking	o. Kind of Business/1	cess'ng
Maryland	d 2 should be filed within th and Mental Hygiene. 7 Ie marked other than treumatic event, the M	To Be (17. Father's Name (First, Middle, Last) Edward 19a. Informant's Name/Relationship (Ti	Trave	v5			Manoke	
	es 1 end 2 of Health a of Health a if item 27 le		20a. Method of Disposition 1 🗹 Burial 2 Cremation 3	Terrioval Itolii State	Place of Disposition cometery, crematory	hurch Creek (Name of or other place)	Rd. Churc	Location - City or 1	10. 2 16.22 Town, State
Baltimore	permit. Pag Department Important: I any Injury o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens		22. Nam He N	eck Cemetery 8/ Be and Address of Floility Ry Fun eral Washington	Home, P. A.	hurch Cr	ceek, MD.
f	Physician /Medical		23a. Pard. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the deal ne cause on each line. a. rena fa Due to (or as a consec	th. Do not enter the			3,7,1	Approximate Interval Between Onset and Death 3 months
	Examiner	Examiner	Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	diebetes Due to (or as a consec	mell	itus			30 years
8760,	death certificate be executed e attending physicien and ad for use as the buriat-transit	Icai	that initiated events resulting in death) Last	Due to (ir as a consected).	quence of):				00 4 62 15
P.O. Box 6	the death certificate the attending place as the action of	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 250 No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	al death 3 □Ectop	r (specify)		23d. Date of deli	very Day Year
	The law requires that the do te has been signed by the page 2 should be detached	þ	Part II. Other significant conditions co dementia	ntributing to death but not res	sulting in the underlyi	ing cause given in Part I.		co use contribute to	the cause of death?
tal Rec	The tay ate has page 2	e Completed	25. Was case referred to medical			OC Please of Do	24a. Was an autopsy performed	? prior to co	topsy findings available completion of cause of
	Physici this cer ral direct	To B	examiner?	Hospital: 1 Inpatient 2 Inpati	28b. Time of Injury	100	Home 5 Residence 28d. Describe how in		ufy)
Divis	D of the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At his building, etc. (Specifical Control of the Control o	(y)		28f. Location (Street City or Town, St	ta fe)	
	the Hospitel hin 24 hours a the Funerel hpletely filled	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death occur ation and/or investiga	rred at the time, date and plac ation, in my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complete	2	29b. Signature and title of certifier Darhouse	du		29c. License number Ho59973 Cambrida	29d.	Date signed (Month)	, Day, Year)
_			30. Name and oddress of person who co	00 Bramble	n 23a) (Type, Print) Street	Cambrida	ge, MO à	2/6/3	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signation 2006	ature	ede !			

			1 - For State Registrar	State of Maryl		artment of rtificate or			Rag. No.	06 28195
ı	Physic		Decedent's Name (First, Middle, Last	ISA.	AC SAYI	ER		2. Date of D Month Augus		3. Time of Death 2006 2:45 A M
	/Medi Exami		4a. Fecility Name (If not institution, give Frederick Mem		ital	4b. City, Town, Fred€	or Location of De		4c. County	
	Funeral Director		213-36-7839	ex 7. Age (In) M 2□ F 89	vrs. last birthday) Yrs.	If Under 1 Yea Months Day		lin. 8. Date of B	irth lay, Year) 5, 1916	Birthplace (State or Foreign Country) Maryland
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Ba-fet	ctor	Maryland Freder	ick		Inion Br	idge			1 ☐ Yes 2 💆 No
	with th	Dire	10e. Street and Number	V-11 D.I		10f. Zip Code			10g. Citizen of	
	ne 234	erai	12154 Green	12. Was Decedent Ever in	n U.S. 13.	Was Decedent of	21791 Hispanic Origin?	(Specify Yes or N		U.S.A.
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or iteme 23a or 28a-f show or other traumatic event, the Midical Examinar must be multified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🖄 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:		lf Yes, specify Cu 1 ☐ Yes 2 ☐ X		(Specify Yes or Nierto Rican, etc.)		ck, White, etc. ^{'Y:} White
5-0	72 hc	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual Occ	e during most of	working	16b. Kind of B	dusiness/Industry
121	within ene. than	d m	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retii farme	,			do turi
	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event.	0	17. Father's Name (First, Middle, Last)		_ 1	raille		Name (First, Middle	e, Maiden Surnar	dairy ma)
Maryland	Mental Mental arked o	To B	lsaac W. Sayler				E	mma May (Geiselma	n
lary	should and Men is marke	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Stree		Rural Route Numi		
	and and malth m 27 in		Dr. Larry J. Warn	<u> </u>			eiver Rd		rick, MI	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		20a. Method of Disposition 1			's Ceme	tery 8/	Date 19/2006	Libert	· City or Town, State ytown,MD
Ball	Departition Depart		21. Signature of Fun yeal Service Licon	16. Alex	/ 22	2. Name and Add	ress of Facility Ha	artzler F	uneral	Home
	10144		23a Part 1 Enter the disease or com	plications that weed the d	6	E. Broa	adway U	nion Brid	dae. MD	21791 Approximate
	Physician /Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cons	EPSIS	er the mode of dy	ying, such as card	nac or respiratory	arrest,	Interval Between Onset and Death
	Examiner		Conversionly lies and distance	Prosta	le (Em cer	,			year
	P ==	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	Due to (or as a cons						
	icate be executed physicien and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cons	seguence of):			· · · · · · · · · · · · · · · · · · ·		
68760,	sicien buria	a			304001100 017.					
687	rtificate ng phys as the	edicai	-	d						
P.O. Box	The law requires that the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnan Other (specify)	су			ite of delivery onth Day Year
of Vital Records, P.	quires that n signed by	b	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cause g	oven in Part I.		tobacco use conf	tribute to the cause of death? 3 Probably 4 Unknown
OS	aw requ s been 2 shouk	Completed						24a. Was		Were autopsy findings available
Ä	The lav	mo.						- auto perf 1 ☐ Yes	ormed?	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of D	Death (Check only		
of √	Physic this co	ို	1 ☐ Yes 2 No		ER/Outpatien	I JLI DOA		Home 5□Res		
nc C	ding F h. After funera	<u></u>	27. Manner of Death 1Ø Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	W		28d. Describe	how injury occur	red
Division	or Atten fter deat director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		at home, farm, str ecify)		☐Yes 2☐No	28f. Location City or To	(Street and Numb wn, State)	per or Rural Route Number,
_	To the Hospital within 24 hours a To the Funeral C completely filled	Medicai C	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of my linar: On the basis of exam	knowledge, death ination and/or in	n occurred at the vestigation, in my	time, date and pla opinion, death oc	ace, and due to the courred at the time	cause(s) and ma	anner as stated. and due to the cause(s)
	To the Within To the	Me	29b. Signature and title of certifier)			nse number		29d. Date signe	d (Month, Day, Year)
	Λ.		•			E .	13091		8-18	- 06
	M20		30. Name and address of person who of	completed cause of death (to Carcle M		Print) 80/	Toll 1	House	Ave,	Fredericle HI
yk.	Sta	-	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature					
DH	Registi MH 17 Rev 1/2		AUG 22	2006 Closus	J. J.	greeke				
		201			67					

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Wayne Stevenson Smith

		1- For State Registrar	,	Certifi	cate of D	eath		Re	eg. No. 20	06 2	819
Physicia Medical Exami		1. Decedent's Name (First, Midd	,					2. Date of Deal Month August 23	Day Year	3. Time of De 0654 hrs	
		Wayne Steven 4a. Facility Name (if not institution	SON SMITH on, give street and number)		4b. (City, Town, or L	ocation of Dea		4c County of E		
		302 Priestford Road			С	hurchville			Harford		
Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs last b		Under 1 Year	If Under 24H		th(MM/DD/YYYY)		or
Director		212 - 70-5453	1 X M 2 F	46	Yrs.	Months Days	Hours M	oct.	21 , 1959「	oreign Country) Mar	yland
		Usual Residence of Decedent									
w any		10a State 10b. County	_	10c. City, Tow						10d Inside C	
daryland 28a-f show 1 at once.	ō	Maryland Harfo 10e. Street and Number	rd	Church	nville	f. Zip Code		14	0.01		27- NO
e Mar or 282	Director	302 Priestfo	rd Road		100	21028		'	Og Citizen of What	Country?	
hours after death with the Maryland matural", or items 23a or 28a-f sho Examiner must be notified at once.		11. Marital Status	12. Was Decedent	Ever in U.S.	13 Was De		anic Origin? (Specify Yes or No		merican Indian, Bla	ack
eath v item	Funeral	1 Never Married 2 XM	arried Armed Forces?			specify Cuban,			White, e		2011,
ifter d	by Fi	3 Widowed 4 Div	orced If Yes, Give Year or Dates:	X No	1 Yes	s 2 No	specify:		Specify:	White	
5-0036 led within 72 hours after Hygiene to other than "natural", the Medical Examiner	ջ	15. Decedent's Education (Spe		npleted) 16a		Jsual Occupation			16b. Kind of Busin		
C1 3 _	Completed	Elementary/Secondary (0-12)	College (1-4 or					Stire u)			
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	m _o	12 17. Father's Name (First, Middle,	; aet)		Concret	e Worke		ne (First, Middle, N		tion Com	pany
215-0 e filed v al Hygi ced othe	BeC	Herbert Wayn					Betty		heets		
21215 should be fill nd Mental H is marked atic event, t		19a. Informant's Name/Relations		1	9b. Mailing Ad				ber, City or Town,	State, Zip Code)	
		Deborah Smith	/ Wife	[3	302 Pri	estford	l Road,	Churchy	ille, MD	21028	
re, M s I and 2 f Health If item 2	- 1	20a. Method of Disposition 1 Surial 2 Cremation	Removal from Str		e of Disposition atory or other p	(Name of ceme place)	etery,	Date	20c. Location - Cı	y or Town, State	
Baltimore, permit Pages I al Department of He Important: If ite	-	4 Denation 5 Other St	pecify:		Air Me	morial	Grdns	8-26-06	Bel Air,	Maryland	đ
Baltimo permit Page Department Important: injury or ott		21. grajure of Fundal Service	Licensee		22 Name MCC	and Address o	neral	Home, P.	Α.		
	_	28a. Part I. Enter the disease, or	complications that appead	the death. De	50 1	West Br	oadway	St., Be	l Air, Ma	ryland 21	1014
Physician /Medical		failure. List only one cause	on each line.			lode of dying, s	ucii as calulac	or respiratory arre	est, shock, or heart	Approximate Between Oil Dea	nset and
Examiner	1	Immediate Cause (Final disease or condition resulting in death)	a Methadone Due to (or as a conse		Clon					Dea	.01
		Sequentially list conditions,	b								
	iner	if any, leading to immediate cause. Enter Underlying Cause.	Due to (or as a conse	equence of):							
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executed an and al - transi				lloos	MEL OF	0/00/06	пт				
e ex	Physician/Medical	X UNPENDED	X AMENDED it	en#281.p n#23a.27	enul, geog .28a-f. de	9,9/28/06 erME.g859	9.9/11/20	06 TT			
S 25 E	N/M	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, outcom	ne of pregnanc	y Fetal d	eath 3	Ectopic pregi	nancv	23d Date of de Month	•	Year
Box 68 e death certi the attendin ed for use as	icia	past 12 months?		time of death		(Specify)			THO INT	Day	Cui
Box 68 ne death certi the attending	hys		known 9 Unknown					-			
irres that the signed by the detached		Part II. Other significant condit	ions contributing to death	n but not result	ing in the unde	rlying cause giv	ven in Part I.		bacco use contribut	_	
ords, I w requires to been sig	Completed by							- 24a. Was a		e autopsy findings	
COFC law re has be	ble							autop perfor	sy prio	to completion of ca	
tal Reco cian: The law certificate has	S	25.14						1 🗸 Yes		Yes 2	No
Division of Vital Records, rat or Attending Physician: The law requir rs after death. al Director: After this certificate has been seen is the funeral director, page 2 should	Be	25. Was case referred to medica examiner?	Hospital: 1 Inpatie	ent 2 FR/	Outpatient 3		of Death (Chec Other Nurs		Residence 6 🗸 ()thes Coope	
n of Vil ding Physic 1. After this funeral dire	٦ ا	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	iry 28b	Time of Injury				now injury occurred	aner. Scene	
ion tendin eath. tor: A the fur	ļį	1 Natural 5 Pend			nd 6:50 a	am 1 Ye	es 2 X No	unk			
ivision for Attenoafter death Director:	ifica	·V	stigation 28e. Place of In				ıldıng, etc.		treet and Number of	r Rural Route Num	ber, City
Divi Hospital or 24 hours afte Funeral Dir	Certification:	4 Homicide deter	rmined (Specify)	House				Pikesvil	treet and Number of tate) 302 Pri Le, MD Ch	irchville,	Mb ,
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use a			hysician: To the best of my						* /		
To the within To the comple	Medical	29b Signature and title of certifie	miner: On the basis of examiner and manner stated	Tirriation and/or		29c License		at the time, date a			- 11
		b 6 A	3			O.C.M				(Month, Day, Year)	
		20 Name and address of passes	who completed cause of d	looth (Ham- OC	,] 0.0.1			August 23, 20	-	
0		 Name and address of person Ling Li, MD Assista 	nt Medical Examine	· ·	,	Baltimore, M	1D 21201				
S	ate	31. Date filed (Month, Day, Year)	32. Begistra								
Regist		êrp n e	2006 1	H	Board						
Dravin II Rev 1/2	TUO	in I	A. Carrier and Car	0	RIGINAL						

			For State Registrer	State of	f Maryland /	Depa	artment of I rtificate of	Health a	and M		gien 9	006	281	97
	Physici	an	1. Decedent's Name (First, Middle	T.	Turner					2. Date of Dea Month	ath Day	Year	3. Time o	f Death
· Age	/Medic	al	Carol				Ab City Town	and anotion		August	19	2006 County of Dea	9:30	A M
e.	Examin	er	4a. Facility Name (If not institution		nber)		4b. City, Town,		Di Dealii			comico	101	
	Funeral		Wicomico Nursir 5. Social Security Number	6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year	If Under		8. Date of Birt (Month, Da	h		rthplace (State	or Foreign
	Director		101-22-8742	1 □ M 2 💆 F	80	Yrs.	Months Days	Hours	Min.	12/20/	1925	5 N	New York	ς
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	ocation						10d. Inside C	City Limits
	Maryl f sho	tor	Maryland Wico	mico	Sal	isbu	ry						X □ Yes	2 □ No
	be filed within 72 hours after death with the Maryland and Hygiene. And other then "neturel", or llems 23a or 28a-f show dother then "neturel", or llems 23a or 28a-f show event, Ire Madical Ex. miner must be notified at	Funeral Director	10e. Street and Number 30161 Provide	nce Drive			10f. Zip Code 218	04			10g. Citiz	en of What C	country?	
	death	nera	11. Marital Status	12. Was Dece	dent Ever in U.S.	13.	Was Decedent of If Yes, specify Cut	Hispanic Ori	gin? (Spe	ecify Yes or No	. 1	4. Race - Am		-
9	or ite	/ Fur	1 Never Married 2 Marr	Armed Fo led 1 ☐ Yes If Yes, Giv	rces? 21 No		If Yes, specify Cut 1 ☐ Yes 2 No			Hican, etc.)		Black, Wh Specify: w	ite, etc. hite	
003	hours urel',	d by	3★ Widowed 4 Divorced	Year or Da	ates:					1				
5	in 72 "net	olete	15. Decedent (Specify only highes	t grade completed)		6a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation i <i>duri</i> ng mos ad)	t of worki	ng	16b. Kir	id of Business	s/industry	
21215-0036	d with giene. rrther	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	Cle					Civ	vilian	Militar	Y
g	al Hyg	Bec	17. Father's Name (First, Middle,	•						(First, Middle,	Maiden .	Surname)		
yla	should to man Ment s marked umatic e	To	Henry M. Kist							Moran				
, Mar	and 2 sh ealth and n 27 is m		19a. Informant's Name/Relations William S. Tu		1		ng Address (Stree 61 Provi							Î
Baltimore, Maryland	Pages 1 and the nent of He net of He net of He net iff item ary or other		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)			5111i20	osition (Name of matery or other pla Demor 1	(1)	8/23)ate /06		cation - City o		
Balti	permit. Pages 1 and 2 should be itied within 72 hours after death with the Marylan Department of Health and Mentle Hygiene. Important: If item 27 is marked other then "neturel; or Items 23a or 28a-f show any injury or other treumatic event, Ir a Madical Examinator must be notified at ORE.		21. Significate of Funer I Service				Holloway 501 Snow	ess of Facili Funer Hill	al H	Home Pro				ation
U			23a Papil. Enter the disease, or effock, or heart failure. List	complications that	aused the death. D								Approxima Interval Be	te
4	Pnysician :		Immediate Cause (Final disease or condition	only one cause on e	July	Cax	IA						Onset and	
	/Medical Examiner		resulting in death)	Due to (or as a consequent	ce of):	μ.							
	Examiner	Ļ.	Sequentially list conditions,	b. — Dunte	THEUM	ONI	A ,							
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequent	De 01).								
Ć.	cate be executed bhysician and the burial-transit	Exai	that initiated events resulting in death) Last	c. Due to (or as a consequent	ce of):								
8760,	te be ysicia ne bur	dlcal		d.										
89	artifica ing ph e as th	Med	IF FEMALE:								-			
Вох	The law requires that the death certific site has been signed by the attending p page 2 should be detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	come of pregnancy irth 2 Petal dea	ath 3[Ectopic pregnand	y			2	3d. Date of de Month	,	Year
P.O.	he de the a	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4∐Pregn 9☐ Unkno	ant at time of death own	1 5L	Other (specify) _							
σ.	that the de ed by the detached		Part II. Other significant condition	ons contributing to de	eath but not resulting	g in the u	inderlying cause gi	ven in Part I		23e. Did to	obacco us	se contribute i	to the cause of	death?
rds	quires tha in signed l uld be det	ed by	DYSPHAGO	1A						101	es 2[]No 3∏F	robably 4	Unknown
CO	law requir as been si 2 should I	plete		,						24a. Was		24b. Were a	utopsy findings completion of	available
Ä	The lav ate has page 2	Completed								autop perfo 1 ☐ Yes	med?	death?		28436 01
Vital Records,	cien; ertifica ector.	Be (25. Was case referred to medical examiner?	11		_				(Check only o	ne)			
of \	Physicien: The la r this certificate ha ral director, page 2	7	1 Yes 2 No 27. Manner of Death	Hospital: 1 🗆 I		Outpatier	IT 3 DOA			me 5 Resid			ecify)	
OUO	ding I h. After funer	tlon	1 Natural 5 Pendin 2 Accident investig	g (Mont	h, Day Year)	Injury	Wo	iryat ork?]Yəs 2. 🗌		28d. Describe h	iow injury	occurred		- 1
Division of	Atten r deat sctor: by the	Certification;	3 Suicide 6 Could	not be 28e. Place	of Injury - At home,	, farm, st				28f. Location (S		Number or F	Rural Route Nun	nber.
Ö	s after	Cert	4 Homicide determ	buildii	ng, etc. (Specify)					City or Tow	vn, State)			,
	To the Hospitel or Attending Physicien: white 24 hours after deals after deals To the Funerel Director: Attenthis certifies completely filled in by the funeral director.	edical (29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physicien: To the Exeminer: On the ba and mann	best of my knowled asis of examination ner stated.	dge, deat and/or in	h occurred at the t vestigation, in my	ime, date an opinion, dea	d place, a	and due to the e	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licen	se number			29d. Date	signed (Mon	th, Day, Year)	
J	30(1)		Mulu	ullar	107	M	1 D	-00	605	73	8	121/	06	
	5114		30. Name and address of person						7.		2 01	201		
	- 0		Maesha Thimman				rnshore I)r., S	alis	bury, M	D 21	801		
	Sta Registr		AUG 2 2	2006	egistrar's Signature	30	arte							

•		riease i	ype or Prin							
		1 For State	State of Ma	rylani	d / Depa	artment of F	lealth and i	Mental Hygi	ene2006	28198
Amend		1 - State Registrar item 20c pe 1. Decedent's Name (First, Middle, Last)		8-22	2-06/ 6 /	THICATE OF	Death		g. No.	
Physicia	an			_				2. Date of Death Month	Day Year	3. Time of Death
/Medic	al	James Winter		Tay	lor	4h Ch Tour	at analisa of Door	Hug. 1	6, 2006	1925 M
Examin	er	4a. Facility Name (If not institution, give s	street and number)	Mai	W./		r Location of Deatl	1 *	4c. County of Dea	•
		5. Social Security Number 6. Sex	//////////////////////////////////////	(In ves. I	ast birthday)	If Under 1 Year	ALISAIN If Under 24 Hrs.	8. Date of Birth		
Funeral Director			\$ M 2□F	84	Yrs.	Months Days	Hour Min.	(Month, Day, Nov. 25	1921 Pen	thplace (State or Foreign ountry) .nsylvania
		Usual Residence of Decedent						1101.23	1721 2011	IIBy I VallIIa
ehow	_	10a. State 10b. County		10c. City	r, Town or Lo	cation				10d. Inside City Limits
Ba-f	cto	Maryland Worces	ster	5	nowh:	111				1XYes 2 □ No
ath with the Maryla 23s or 28s-1 ehov	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What C	ountry?
death with the Maryland ms 23s or 28s-f ehow		111 South Colli				2186			U.S.A	
	Funeral	11. Marital Status 1 ☐ Never Married 2 ★ Married	12. Was Decedent En		S. 13. \	Was Decedent of F f Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
irs af	by F	3 Widowed 4 Divorced	1 XYes 2 □ No If Yes, Give Year or Dates:	י מנת ח		I∐Yes 2, No	Specify:		Specify: D	lack
be filed within 72 hours after lal Hygiene. d other then "natural", or ite event, the Medical Examine	ed	15. Decedent's Edu	cation	₹W 2	16a. Deced	lent's Usual Occup	ation	1	6b. Kind of Business	
7 uin 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+	,	(Give life. l	kind of work done DO NOT use retired	during most of word)	king		,
d with	Completed	Libinositaly/obcolidaly (0-12)	5+	'	Psych	no Thera	apist		None	
al Hy loth	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nar	ne (First, Middle, M	aiden Surname)	
Ment b	2	Ira Taylor					Molly	Robinso	n	
s 1 and 2 should be filed within 72 hd Health and Mental Hygiene. Item 27 is marked other then "natur other treumatic event, the Mudical		19a. Informant's Name/Relationship (Ty	pe, Print)						City or Town, State,	
and ealth m 27		Anne Taylor (Wif	e)	T==- =-	111		ins St.		,Md.2186	
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny Injury or other trei		20a. Method of Disposition 1	emoval from State	20b. PI	lace of Dispo emetery, cren	sition (Name of natory or other plac	ce)	Date 2	Oc. Location - City of	Town, State MD
Pag Imen Iant: jury		4 □ Donation 5 □ Other (Specify)		Ebe		: Cemete		1-2006	Snowhil:	
permit Depar Impor eny In		21. Signature of Funeral Service License	**		22	Name and Addre	Funera:	. Home	Md.2180	
70 F • 0		Bladys B. 2	Soward							
		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused t ne cause on each line	he death	. Do not ent	er the mode of dyin	ig, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
Physician	ı	Immediate Cause (Final disease or condition resulting in death)	Acco	D CE	reino	a of	Long			6 mon This
/Medical Examiner		resulting in dealin)	Due to (or as a	consequ	ience of):					
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ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	00010 (01 20 2	00110040	101.00 017.					
be executed sicien and burial-transit	xar	that initiated events cresulting in death) Last	Due to (or as a	consequ	ence of):					-
bur icie	cai									
law requires that the death certifical as been signed by the attending ph. 2 should be detached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of	pregnar					23d. Date of de	livery
death	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at ti			Ectopic pregnancy Other <i>(specify)</i>			Month	Day Year
tt the by th tache	hys	9 Unknown	9□ Unknown						4	
es thai igned t	by P	Part II. Other significant conditions con	tributing to death but	not resu	Iting in the ur	nderlying cause giv	en in Part I.	23e. Did toba	icco use contribute t	the cause of death?
equir en si buld l	ed	Preumonia						Yes	2 □ No 3 □ P	robably 4 Unknown
law ra as be 2 sh	pie	<u></u>						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
The ete h page	E							performe	ed? death?	2 No
icien: Th	Be (25. Was case referred to medical examiner?					26. Place of Dea	th (Check only one)		
Physic this ce al dire	၉	1 ☐ Yes 25 No	ospital: 1 Xinpatien	2 🗆 🛭	ER/Outpatien		4 Inursing n	ome 5 ☐ Residen	ce 6 ☐Other (Spe	cify)
ding P. h. After I	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe how	injury occurred	
tend death tor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 □No			
or Al	Certification:	4 Homicide determined	28e. Place of Injur- building, etc.	y - At hou (Specify	me, farm, str	eet, factory, office		28t. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
Hospital or Attending Physicien: 14 hours after death. Funeral Director: After this certifio tely filled in by the funeral director,		29a. Certifier 1 Certifying Phys	sician: To the best of	my know	vledge death	occurred at the tin	no, data and place	and due to the sec	(a) and minner	
- LV - 0	Medical	(Check only 2 Medical Examinations)	ner: On the basis of e	xaminati	ion and/or inv	restigation, in my o	pinion, death occu	rred at the time, dat	e and place, and du	o to the cause(s)
within To the compl	ž	29b. Signature and title of certifier	/			29c. Licens		290	d. Date signed (Mon	h, Day, Year)
Jan Jan		() < /	ent :	m. C	,	230	2690	U	Aus. 17,	2006
(D)		30. Name and address of person who co	mpleted cause of dea				60011	5t. 501	1.56000	MO
Sta		31. Date filed (Month, Day, Year) AUG 2 2 200	22 Praictens	's Signat	ure			,		- (
Registr	ar	nud & & ZUI	JU DEGUE	1	7. 40	alle)	-			

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State of Ma	aryland / Depa	rtment of He	ealth and Me	ental Hygiene	3006

			For State Registrar	State of M		partmen <i>ertificat</i>				giene Reg. No		28199	
	Division		1. Decedent's Name (First, Middle, I	ast)					2. Date of De		*	3. Time of Death	
	Physici /Medio		William Oliv				-		Augus	st, 1	5, 2006	4:18 P M	
1	Examir	er	4a. Facility Name (If not institution, g 12602 Connecti			1		ocation of Deat. Spring	h	4c	. County of Dea Mon to	th Omery	
-	Funeral				Θ (In yrs. last birtho	ay) If Under	1 Year	If Under 24 Hrs	8. Date of Bir	th	9 Bir	thplace (State or Foreign	
	Director		230-42-7126	13 X M 2 ☐ F	72 Yrs	Months	Days	Hours Min.	Dec. 3	0, 1	933 V	irginia	
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town o	r Location						10d. Inside City Limits	
	Maryl f sho	Į	Maryland Mo	ntgomery	Silve	r Sprin	na					1 □ Yes ¥™ No	
	h the	rec	10e. Street and Number			10f. Zip				10g. Cit	tizen of What Co	ountry?	
	death with the Maryland rms 23a or 28a-f show rmat be notified at	aD	12602 Connecti	cut Avenue			20906				USA		
Maryland 21215-0036	n 72 hours after death with the Marylan "natural", or Items 23a or 28a-f ahow salcal Examinat ha notilied at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:	Ever in U.S.	I3. Was Deced If Yes, spec 1 ☐ Yes		panic Origin? (S , Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		14. Race - Ame Black, Whit Specify: Whi	te, etc.	
5-0	natu	etec	15. Decedent's (Specify only highest of	Education trade completed)	1 (0	ecedent's Usua live kind of wo	rk done du	ion ring most of wo	rking	16b. K	and of Business	/Industry	
12	withir ene. then	Completed by	Elementary/Secondary (0-12)	College (1-4or : 3	5+)	ctrical		ineer		WGMS	Classi	cal Radio	
D	permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nu any Injury ac other traumatic avant, the Media once.	Be C	17. Father's Name (First, Middle, La	st)			1	8. Mother's Na	me (First, Middle,	Maiden	Sumame)		
ylar	Menta Menta arked	To	William Dabney	Thompson		_		Mary 1	Lucille	Fann	in		
Jan	2 short and 18 mu		19a. Informant's Name/Relationship			-			ural Route Numbe				
e,	1 and Health em 27		June Fay Thomps 20a. Method of Disposition	on/ Wife	20b. Place of D	sposition (Nar	ne of		enue, Si Date		Spring	Town State	
Baltimore,	Sages At: Fit		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		Gate of F	crematory or o	ther place)	, Lauc	just 21				
alti	oortar		21. Signature of Funeral Service Lic	ensee		- 22 Name an	d Address		006 ; Funeral			ng, Maryland	
ä	50 E 8 8		1 delly cu	u farke					d, W, Si			, MD 20901	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused by one cause on each li	the death. Do not ne.	enter the mod	le of dying,	such as cardia	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- u	Artery		2					2 Years	
	Examiner			. Due to (or as	a consequence of)								
4	D ==	ner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a dui sequence of,			-		-			
	ecuter and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to /or se	a consequence of)								
68760,	ficate be executed g physician and is the burial-transit	a E			a consequence or,								
687	= 00 d	edlcal		d.									
P.O. Box	requires that the death certifi een signed by the attending nould be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetel death	3 □Ectopic pr 5 □ Other (sp					23d. Date of del Month	livery Day Year	
	gned b		Part II. Other significant conditions	contributing to death b	ut not resulting in th	e underlying c	ause given	in Part I.	23e. Did to	obacco i	use contribute to	the cause of death?	
ord	w require been sign	ted	Rheumatoid Arth	rit i s					10`	res 2	No 3□Pr	robably 4 Unknown	
ec	> Q to	Completed by							24a. Was autor	osy	prior to	utopsy findings available completion of cause of	
a F	n: The								1 ☐ Yes	rmed? 2□ No 	death? 1 ☐ Yes	2 □ No	
Z.	siciar certif irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ER/Outpa	tiont 20 DC	Other		ath (Check only o		0 DON (0	-16.1	
of	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Inju	ry 28b. Tim		28c. Injury a Work?	4 Nursing r	lome 5 Resid			city)	
ion	ath. or: Aft	atlo	1 ☐xtatural 5 ☐ Pending 2 ☐ Accident investigat		y Yea <i>r)</i> Inju	M		s 2□No					
Division of Vital Records,	or Attendentinecte	all l	3 Suicide 6 Could not determine	286. Place of Inj	ury - At home, farm c. (Specify)	street, factory	y, office		28f. Location (S City or Tox			ural Route Number,	
	pital ours a oral D	Ce	29a. Certifier	Physicians To the boot	of my knowledge .	and a second	- A Ab - Aires	deta d -1			\		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:	(Check only one)	Physician: To the best aminer: On the basis o and manner st	f examination and/o	r investigation	, in my opir	nion, death occi	rred at the time,	date and	d place, and due	o stated. o to the cause(s)	
	To th To th comp	Me	29b. Signature and title of certifier			290	c. License r			29d. Da	te signed (Mont	h, Day, Year)	
			1 miles				υ2.	1340		Aug	just 16,	2006	
	10		30. Name and address of person wh		leath (Item 23a) (Ty L Ferrara		Whe	aton Mi	20902				
	Sta	te.	Raymond Bass, 31 Date filed (Month, Day, Year)					acon, m					
	Registi												

	1- For State of Registrar	Maryland / Department of Health Certificate of Deat	and Mental Hygiene	28200
Physician /Medical Examiner Funeral Director	4a. Facility Name (If not institution, give street and num Doroles for General 5. Social Security Number 214-26-6553 1 M 2 F	Hospital Cambin	ler 24 Hrs. 8. Date of Birth 9. 8. S Min. (Month, Day, Xear) 9. 8	6 0817 AM
ore, Maryland 21215-0036 les 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If them 27 is marked other than "nature!, or Items 23s or 28e-1 show or other treumetic event, the Madical Examiner must be notified at To Be Completed by Funeral Director	Armed For	16a. Decedent's Usual Occupation (Give kind of work done during m life. Do NOT use retired) 19b. Mailing Address (Street and Num P.O. Box 203 East 20b. Place of Disposition (Name of cemetary, crematory or other place)	fy: Specify: Specify: Nost of working Aberdeen Ground ther's Name (First, Middle, Maiden Sumame) Mary Catherine Denbow Taber or Rural Route Number, City or Town, State, New Market, MD 21631 Date 20c. Location - City or	nerican Indian, iite, etc. White s/Industry Proving Zip Code)
Baltimore, North East of the Pages 1 and Department of Health Dibysician and Diby	23a. Pert1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ear limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	22. Name and Address of Factors 700 Locust States and Address of Factors and Address of Fa		, P.A.
al Records, P.O. Box 68 The law requires that the death certifica cate has been signed by the attending pr page 2 should be detached for use as the	in the past 12 months?	ath but not resulting in the underlying cause given in Par	1 Yes 2 No 3 F	Day Year to the cause of death? Probably 4 Unknown ulutopsy findings available completion of cause of
Sion of Vita tending Physician leath. for: After this certifi the funeral director catlon; To Be	27. Menney of Death 1 Natural 5 Pending (Month) 2 Accident investigation	patient 2 FR/Outpatient 3 DOA Other: 4	ce of Death (Check only one) Nursing Home 5 Residence 6 Other (Sp 28d. Describe how injury occurred No 28f. Location (Street and Number or F City or Town, State)	
Divi. To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	(Check only 2 Medicel Exeminer: On the base and manns and manns 29b. Signature and title of certifier 30. Name and address of person who completed cause	29c. License numbe #0059 of death (Item 23a) (Type, Print)	eath occurred at the time, date and place, and du r 29d. Date signed (Mon	e to the cause(s) th, Day, Year)
State Registrar	31. Date filed (Month AUG 2 1 2006 32. F	istrar's Signature		

			1 - For State Registrer	State of Ma	ryland	/ Depa	rtment o	f Health and of Death	d Mental Hyg	giene 2006	28201
*	Physici	an	Decedent's Name (First, Middle, La	Ruth	Ta	ofki	ch		2. Date of Dea Month	ath Day Year	3. Time of Death
*	/Medi Examir		4a. Facility Name (If not institution, giver Copper Ridge	ve street and number)	·	, .	4b. City, Tow	n, or Location of De sville		18, 2006 4c. County of Death Carroll	6:25 A M
	Funeral Director	Sign .	Social Security Number 6. 8	Sex 7. Age	(In yrs. las	t birthday) Yrs.	If Under 1 Ye Months Da	ar If Under 24 F	in (Month, Day	h 9. Birth	place (State or Foreign intry) svlvania
	ס	or	Usual Residence of Decedent 10a. State 10b. County		10c. City, T				1100.10	, 1923 1 61111	10d. fnside City Limits 1 ☐ Yes 2 ☐ No
	th with the A 23a or 28a-	Funeral Director	Maryland Freder 10e. Street and Number 3116 Pheasant Ri		тја	msvil	10f. Zip Coo	21754		10g. Citizen of What Cou	
36	rs after dea I', or Items	by Funer	11. Marital Status 1 □ Never Married 2 □ Marned 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ②N If Yes, Give Year or Dates:			Vas Decedent Yes, specify ((Specify Yes or No- erto Rican, etc.)		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Manial Pygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Madical Examiner must be motified at once.	Completed I	15. Decedent's E (Specify only highest grants) (Secondary (0-12) 1 2	ducation		(Give :	OO NOT use re	ne during most of v rired)	vorking	16b. Kind of Business/li	
land 5	uld be filed v fental Hygie rked other t tic event, Ib	To Be Co	17. Father's Name (First, Middle, Last Ott Herman	Eichner			lomemak	18. Mother's N	lame (First, Middle, th Furn	Maiden Sumame)	поше
Maryland	nd 2 shor alth and A 27 Is ma or trauma		19a. Informant's Name/Relationship (Ruth Mary Gregor		r	19b. Mailin 3116	g Address <i>(Str</i> Pheasa:	eet and Number or nt Run, I	Rural Route Numbe jamsville	r, City or Town, State, Zi	21754
Baltimore,	Pages 1 a ment of Hei ant: If item ury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Denation 5 ☐ Other (Special		cem	etery, crem	sition (Name of latory or other Cemet	olace)	Date . 24, 06	20c. Location - City or T	
Balt	permit. Departimport any inj		21. Signature of Funeral Service Lices	Tilli.	mr) 22 M 2	Name and Ad 81esw8	dress of Facility th-Willi ldge Road	ams P.A. Damasc	Funeral Hous, Marylan	me 20872
* *	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	pfications that caused one cause on each line a). 	Cen	or the mode of	0	iac or respiratory ari	rest,	Approximate Interval Between Onset and Death
38760,	cate be executed physicien and the burial-transit	dical Examiner	day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	·	,					
P.O. Box 68	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 19 Unknown	Fetal de	ath 3 🗆	Ectopic pregna Other (s <i>pecify</i>			23d. Date of delive	ery Day Year
	The law requires that the ste has been signed by th bage 2 should be detache	by	Part II. Other significant conditions of	contributing to death but	not resultir	ng in the un	derlying cause	given in Part I.	23e. Did to	bacco use contribute to t	he cause of death?
al Records,	nysician: The law re nis certificate has be I director, page 2 sho	Completed							24a. Was a autops perfor	sv prior to co	opsy findings available impletion of cause of
f Vit	hysician nis certifi I director	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	Hospitaf: 1 ☐ Inpatien	2 ER	VOutpatient	3□ DOA	24	eath <i>(Check only or</i>	ne) ence 6 □Other (Speci	(y)
Division of Vital	ding Plans. After tl	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	e Zeo Place of Initia	Year)	Bb. Time of Injury	M 1	ljuryat Vork? □Yes 2□No	28d. Describe he	ow injury occurred	
<u>></u>	i Qifte		4 Homicide determined	building, etc.	(Specify)				City or Town	•	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	one)	niner: On the best of and manner state	examination	idge, death n and/or inv	estigation, in m	y opinion, death oc	curred at the time, d	ause(s) and manner as s late and place, and due t	o the cause(s)
)	or With	-	29b. Signature and title of certifier	m(gree	mo			onse number 000 S 9 9 9 9		Agust 18	Day, Year)
	D		30. Name and address of person who	completed cause of de	ath (Item 23	Ba) (Type, F	Print) Svite	307 ve	3/minste	V MO 21	157
A. S. S. S.	Sta Registr		31. Date filed (Month Day Year) AUG 2 2	2006 32. Figistrar	's Signature	4	ande		1-		

		1 - State Amend Item 2	State of M	aryland /	Depi Cel	06/06d	of He	ealth a <i>eath</i>	nd Me	ntal Hyg	giene	200	6	2820
1	*	Decedent's Name (First, Middle, Las.								2. Date of Dea	ith			3. Time of Dea
Physici /Medic	al	HEU TH	TRAN							08 Wouth	2 ^{Day}	20	90°	02 10
Examin	er	4a. Facility Name (If not institution, give LAVPEC REGIONAL	HOSPITAZ			0.01	iez				pn	County of 1		2046
Funeral Director		219-39-7336	x 7. A	ge (In yrs. last b	Yrs.	If Under 1 Months I	Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day Aug 2,	/, Year)		Count	ace (State or For ry) n Vietna
tryland thow		Usuel Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation							10	d. Inside City Lir
the Marylar 28a-f ehow	ecto	MD Prince G	eorge	Laure	21	10f. Zip C	ado.				10a Citi	zen of Wha	Cour	1 🔀 Yes 2 🗆
23a or	ai Di	7607 Laurel Ridge	Court			207						5.A.	i Coom	ıyı
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 ie marked other than "natural", or Items 23a or 28a-1 ehow other traumatic event, the Maddoal Examiner or the notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	?	1	Was Deceder f Yes, specify 1 ☐ Yes 2		panic Origi , Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or No- can, etc.)	ì	14. Race - A Black, \ Specify:		tc.
within 72 ho ene. than "natur to wed cal	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		5+)	(Give life. I	dent's Usual (kind of work DO NOT use etary	done du	ion iring most	of working			nd of Busin		ustry
Hygie other	Be Co	17. Father's Name (First, Middle, Last)	4		ecre	ecary		8. Mother	's Name (First, Middle,		Gumame)	ent	
2 should be filed and Mental Hygi ie marked other aumatic event,	ToB	Thang Van Tran						Duon	g Thi	Nguye	n			
nd 2 sho alth and 27 ie m ir traum	1	19a. Informant's Name/Relationship (T)								Route Numbe	,			,
0°= 5		Quyen Nguyen /dau 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	20b. Place cemete	of Dispo	Laure. sition (Name natory or othe Cemete	of ir place,	Ì	Dat	, Laur	20c. Lo	cation - Cit	or Tov	m, State
permit. Pag Department Important: any injury o		21. Signature Funeral Service Licens	,	M00773	22 I	Name and Donald	Address SON	of Facility Fune:	ral H	ome, P	.A.			07-4389
Physician /Medical Examiner	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	+ of):	Aspira	tion phan	n Pne	umoni al Dy					Approximate interval Between Onset and Death 24 In 28
The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[\text{Yes} 2 \] No 9 \[\text{Unknown} \]	d	2 Fetal deat	h 3[Ectopic pregi					2	3d. Date of Month		/ Day Year
w requires that been signed b should be deta	þ	Part II. Other significant conditions co	ntributing to death t			nderlying caus	se given	in Part I.			bacco us			cause of death?
	Completed									24a. Was a autops perform	sy _	prior	to com	sy findings availa pletion of cause
0 0 6	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 Anpati	ent 2 ER/O	utnation	1 3□ DOA	Other			Check on on 5 ☐ Reside		Other (
nding ath. r: After e fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		Time of Injury		Injury a Work?		280	d. Describe ho			ор <i>еспу)</i>	
tel or Attendir s after death. el Director: Af ed in by the fu	Certification:	3 ☐ Suïcide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, e	ury - At home, f c. (Specify)	arm, stre	eet, factory, o	fice		28f	Location (St City or Town		Number o	r Rurai	Route Number,
To the Hospitel or Atte within 24 hours after dei To the Funerel Directo completely filled in by th	edlcai (29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best ner: On the basis of and manner st	it examination ai	e daam nd/or inv	decumed at t estigation, in	ne time my opir	data and non, death	place, and occurred	dua to the or at the time, d	luce(c) t ate and	and manne place, and	due to t	ed. he cause(s)
Toth	Ž	29b. Signature and title of centrier	~5	~~	•	29c. L	cense i	number	74	2	9d. Date	signed (M	onth, D	ay, Year)
(5)		30. Name and address of person who co	wan W	death (Item 23a)	(Туре, I	Print)	PA	rvxoî	NT P	KLIY	رىي	umai	2 r	NO 2152
Sta Registra		31. Date filed (Month, Day, Year) CFD 0 6 2006	32. Registr	ar's Signature	age of	, , ,								

1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Reg. NZ U U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** John Linwood Wall 1:00 P Aug 19, 2006 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**X**] M 2□ F Days Hours Min 219-58-8720 **Director** Jul 29, 1952 Maryland Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 7 is marked other then "netural", or items 23e or 28e-f show treumetic event, the Madical Examinar must be notified at 10d. Inside City Limits Director MD Calvert 1 ☐ Yes 2 No Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 315 Crestwood Drive Apt. #107 20678 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ Specify: Black 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then " Elementary/Secondary (0-12) College (1-4or 5+) 9 Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Wall Susie King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vera Lee Johnson/sister P.O. Box 151 Lusby, MD 20657 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State injury or ¹ 4 □ Donation 5 □ Other (Specify) 08/22/06 Alexandria, VA Metropolitan Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility eny Sewell Funeral Home Ellady a 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final M ETASTATIC **Physician** ESOPHAGEAL disease or condition resulting in death) CARCINGMA 6 MONTHS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate caus. End of being Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ LCO HOUIS 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of this certificate has autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No the Hospitel or Attending Physicien: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? After Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after 4 Homicide within 24 hours a To the Funerel I Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) D26358 AUC 20, 2006 address of person who compl d carse of death (Item 23a) (Type, Print) INCE FREDERICK, MJ-20618 WEIGHT 31. Date filed (Month, Day, Year) 32. Registras Signature State 22 2006 Registrar

cia lica	n	1. Decedent's Name (First, Middle	H8/18/06, BM 9. Last)						Date of Death Month			Time of D	eath
	al .	Margaret Eliz							August	*		:42 r	о М
iine	er	4a. Facility Name (Knot institution	HABILITAT	TON AND)	4b. City, Town		of Death		4c. County o			
		NURS ING CENTER 5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday	Burton If Under 1 Yes		24 Hrs o	Date of Blats	Montg		(0)	
al or		212 22 2093	1 M 2 F	80	Yrs.	Months Day		Min. A	Date of Birth (Month, Day, ugus t 15	7006 V	9. Birthplace Country) Virgini	(State of t La	-oreign
		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ecation					10d Ir	nside City	Limite
	ö	Maryland Montg	070 777									Yes 2	
	ect	10e. Street and Number	omery	311	ver Sp	10f. Zip Code			10	g. Citizen of W	hat Country?		
	<u> </u>	1006 Rosemere A	venue			20904				JSA	, , ,		
	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Decedent o	f Hispanic Ori	gin? (Specif	y Yes or No-		- American In	dian,	
ŀ	2	1 Never Married 2 Marr	ied 1 ☐ Yes	217 No		1 □ Yes 2XIN		i, Pueno na	an, etc.)		k, White, etc. Wh	ite	
:	d by	3 ₺ Widowed 4 Divorced		Dates:						Specify:			
	Completed	15. Deceden (Specify only higher			16a. Deced	dent's Usual Occ kind of work dor DO NOT use reti	upation le during most	t of working	1	6b. Kind of Bus	siness/Industry	/	
	E C	Elementary/Secondary (0-12)	College (1-4or 5+)		eria Wo:			1	fontgomablic S	ery Cou	inty	
1	BeC	17. Father's Name (First, Middle,	Last)				1	er's Name (F	First, Middle, M.				
	일	Herbert	Neel				Man	сy	I	uckett			
		19a Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Stre	et and Numbe	or or Rural F	Route Number,	City or Town, S	State, Zip Code	в)	
+		Theresa L. Lech	ter/Daugh			Roseme	re Aver	nue, S	Silver S	Spring,	Mary1a	and 2	20904
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from	State T or	lace of Dispo	sition (Name of matory or other p ited Met	lace)	Augu		Oc. Location - C	City or Town, S	State	
		4 □ Donation 5 □ Other (S	pecify)	Chu	rch Ce	netery	nodist	19,20		artfiel	d, Virg	inia	
		21. Signature of Funeral Service	Licensee	า		Name and Add			uneral	Ното	Tna	2090)1
7		Michen	How	le	5	00 Unive	reity P	llvd.	West.Si	lver Spr	ing Ma	rylar	d
		23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on	caused the deat each line.	h. Do not ent	er the mode of d	ying, such as	cardiac or r	espiratory arres	st,	Inte	roximate rval Betwe et and De	
1		Immediate Cause (Final disease or condition resulting in death)	a P	arkinso	n's Di	sease					Yea		alli
		rooding in douting	Due to	(or as a conseq	uence of):								
ı	-	Sequentially list conditions,	b. — Due to	(or as a nonsec	wance off:						_		
7.		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(
١,	Examiner	that initiated events resulting in death) Last	C	(or as a conseq	uence of):								
	dical		d										
	Med	IF FFMALE.								1			
	5	IF FEMALE:		tcome of pregna		Ectopic pregnar	ncv				of delivery		
	a	23b. Was decedent pregnant	I LITINO I	nant at time of d		Other (specify)				Mont	th Day	Ye	ar
	siclan	in the past 12 months? 1 □ Yes 2 ☒ No	4 ☐ Prega										
	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregr 9□Unkn	own	. dai i - ab				On Didas				
	፭	in the past 12 months? 1 □ Yes 2 ☒ No	4□Pregr 9□Unkn	own	ulting in the u	nderlying cause	given in Part I.			cco use contri			KIIOWII
	፭	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown Part II. Other significant condition	4□Pregr 9□Unkn	own	ulting in the u	nderlying cause	given in Part I.		1 □ Yes	215 No 3	3 🗌 Probably	4 🗆 Uni	
	፭	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown Part II. Other significant condition	4□Pregr 9□Unkn	own	ulting in the u	nderlying cause	given in Part I.		1 ☐ Yes 24a. Was an autopsy	215 No 3	3 Probably	4 🗆 Uni	
	Completed by	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown Part II. Other significant condition Dementia	4 □ Pregi 9 □ Unkn	own	ulting in the u	nderlying cause			1 Yes 24a. Was an autopsy perform 1 Yes 2	24b. W pr de No 1	3 🗌 Probably	4 Uni	
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	edical Certification: To Be Completed by	in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition Dementia 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Shatural 5 Pendin investing 3 Suicide 4 Homicide 6 Could determ 29a. Certifier Chack on 2 Medical 3 Signature and title of certifier Chack on 2 Medical 2 Medical 3	Hospital: Gatton not be ined 28e. Place build Inpatient 2 of Injury th, Day Year) a of Injury - At heing, etc. (Specified best of my known and restated.	ER/Outpatier 28b. Time of Injury ome, farm, str y)	ot 3 DOA Control of 28c. In Man Man Man Man Man Man Man Man Man Ma	26. Place Other: 4 Nu jury at lork? Yes 2 1 e time, date an y opinion, deal	of Death (Crsing Home 286)	1 Yes 24a. Was an autopsy perform 1 Yes 24 Check only one 5 Residen 1. Describe how Location (Street City or Town, at the time, dat	2 No 24b. W pr de	Grant Round	4 Unings avion of cau No te Number cause(s)	ariable se of	
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DHMH 17 Rev 1/2001

			For State Registrar		State o	f Maryla	and / Dep <i>Ce</i>	artmen rtificat	t of H	ealth a	and M	lental Hy	giene Reg. No	20	06	282	05
	Dhusia		1. Decedent's Name (First, Midd	le, Last)		-			-			2. Date of De Month	ath Da	ıv	Year	3. Time of D	eath
	Physici /Medi		GEORGE ASBURY	WADE,	SR.							AUGUST	16	•	2006	3:32	Рм
	Examir		4a. Facility Name (If not institution	n, give s	treet and nur	nber)		4b. City,	Town, or	Location of	of Death		40	. County	of Death		
			HOLY CROSS REHAL							ONSVIL			N	ONTG			
	Funeral		5. Social Security Number	6. Sex	M 2□ F	7. Age (In y	rs. last birthday, Yrs.	If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year,	,	9. Birthp	lace (State or F try)	-oreign
	Director		579-12-7187 Usual Residence of Decedent			86	TIS.					APRIL 17	, 19	20	ITHAC	A, NEW Y	ORK
	land w		10a. State 10b. Count	,		10c.	City, Town or L	ocation							1	0d. Inside City	Limits
	Mary 1.eh	ō	MARYLAND MONTO	OMEDV			מתמומ	NCXITI I								1 ☐ Yes 2	. No
	28.	Director	10e. Street and Number	OPEKI			DUKIC	NSVILL 10f. Zip					10g. Ci	tizen of \	What Cour	try?	
	ours after death with the Maryland rei', or iteme 23s or 28s-1 show Examinat must be notified at		3009 WINIFRED DR	TVF					2086	4						•	
	death	by Funeral	11. Marital Status		2. Was Dece	dent Ever in	U.S. 13.	Was Dece			gin? (Spe	ecify Yes or No Rican, etc.)	-		e - Americ		
9		Ē	1 ☐ Never Married 2 🔀 Ma	ried	Armed Fo	2 🗆 No					, Puerto	Rican, etc.)			ck, White,	etc.	
93	hours after turel', or its al Exemina	3 by	3 ☐ Widowed 4 ☐ Divorce	1	If Yes, Giv Year or D		II	1 🗆 Yes	2 KU NO	Specify:				Specify	WHI:	Œ	
21215-0036	72 hours "naturel", idical Exp	Completed	15. Decede (Specify only highe	nt's Educ	ation completed)		16a. Dece	dent's Usua	al Occupa	ition uring most	of works	na	16b. H	(ind of B	usiness/Ind	dustry	
21	within ene. then "	du	Elementary/Secondary (0-12)	1	College (1	-4or 5+)	life.	kind of wo DO NOT u	se retired,)		9					
	filed within the Hygiene. other then	S	12				CAR	SALES	MAN					TOMOB			
P	be fill H d oth	Be	17. Father's Name (First, Middle	Last)						18. Mothe	r's Name	(First, Middle,	Maider	Suman	10)		
yla	2 should be and Mental is marked oumatic ev	은	SAMUEL ASBUR				-					JOHNSON					
Maryland	s 1 and 2 should be filed within 72 he f Health and Mental Hygiene. Itsm 27 is marked other then "natur	li	19a. Informant's Name/Relation	ship (Typ	e, Print)		19b. Maili	ng Address	(Street a	nd Numbe	r or Rura	l Route Numbe	er, City	or Town,	State, Zip	Code)	
	of Health a		CAROLYN WADE -	WIFE		l a a i	3009	WINIFR	ED DR	EVE, BI		SVILLE, M					
Baltimore,	H H H H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Re	moval from		 Place of Disposer cemetery, cre 	nsition (Nar matory or o	ne of ther place	•)	D	ate	20c. L	ocation -	City or To	wn, State	
Ë	permit. Pages 1 Depertment of H Importent: if its any injury or of		4 ☐ Donation 5 ☐ Other (- 1	SATE OF HE	EAVEN C	EMETE	RY A	UGUST	22,2006	S.	ILVER	SPRIN	G MARYLA	AND
Sall	epert epert nport ny in		21. Signature of Funeral Service	License	θ	+	2	2. Name an	d Addres	s of Facility	y H	INES-RINA	LDI	FUNER	AL HOM	E, INC	
ш	<u>v</u> ∪ E ≅ 9		Nanny A	V-c	cen	Nu.	1	1800 N	EW HAI	IPSHIKI	E AVEI	WE, SILV	EK S	PKING	, MAKY	LAND 209	U4
760,	Physician /Medical Examiner pnuishtransit	cai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, farly, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.b.c.	Due to (IDENT								Onset and De.	ain
P.O. Box 687	uires that the death certificate be executed signed by the ettending physicien and id be detached for use as the burial-transit	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregn 9□Unkno	inth 2 ☐ Fe ant at time o own	etal death 3[f death 5[Ectopic pr Other (sp	ecity)					23d. Dat Mo	te of delive	ry Day Yea	ar
	w requires that the been signed by th should be detache	ed by	Part II. Other significant conditions CORONARY ARTEI					nderlying c	ause give	n in Part I.						e cause of dea ably 4 ⊟Uni	
Records,	sicien: The law r certificete has be irector, page 2 sh	Completed	FAILURE TO THI	RIVE,	COMFORT	CARE						24a. Was autop perfo 1 Yes	sy rm <u>e</u> d?		Were autor prior to con death?	osy findings avanpletion of cause	ailable se of
Vital	ratifica stor.	Bec	25. Was case referred to medica examiner?	E _						26. Place	of Death	(Check only o	-	10			
>	Physicien: this certific ral director.	2	1 ☐ Yes 2 ☒ No	Ho	ospital:	npatient 2	☐ ER/Outpatier	nt 3□ DC	Othe	r. 4⊠ Nu	rsing Hon	ne 5□Resid	dence	6 □Oth	er (Specify)	
Division of	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.			gation	28a. Date of (Monte	of Injury h, Day Year)	28b. Time o Injury	M 2	8c. Injury Work 1 🗆 Y		2	8d. Describe h					
Divis	ital or Att rs after d rei Direct led in by t	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr		28e. Ptace buildir	of Injury - At ng, etc. <i>(Spe</i>	t home, farm, str cify)	eet, factory	, office		2	28f. Location (S City or Tox			er or Rura	Route Numbe	r.
	To the Hospital within 24 hours a To the Funerei I completely filled	Medicai	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physi Examin	er: On the ba and mann	asis of exami	nowledge, deat ination and/or in	n occurred vestigation,	at the time in my op	e, date and inion, deat	d place, a h occurre	and due to the dead at the time,	date an) and ma d place, a	inner as stand due to	ated. the cause(s)	
	Tol	2	29b. Signature and title of certific	N IA	16100	10-		290	. License	number			29d. Da	te signed	d (Month, l	Day, Year)	
			· R. any	urv	vour				D5	3367			AUGU	ST 18	3, 2006	5	
		Ì	30. Name and address of person	who con	npleted caus	e of death (It	tem 23a) (Type,	Print)									
			RAJAN SHYAMSUNDA	R,MD.				SUITE	117,	SILVER	SPRI	NG, MARYI	LAND	20902	2		
	Sta Registi		31. Date filed (Month, Day, Year AUG 2	200										W 501			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Charles Roland Walsh, Jr. August 19, 2006 0645 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll Hospital Center Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 19, 19 **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1**⊠**M 2□ F 29 214-04-5070 Yrs. Director Maryland 1976 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Itams 23a or 28a-f show other treumstic event, the Madical Examenar until by motified at Westminster Maryland Carroll 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 212 Goodwins Quarry, apt 2 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Itan any Inlury or other treumatic event, the Medical Examination. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A Disabled 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Deborah Ann Leisner Charles R. Walsh, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Deborah A. Leisner, mother 2927 Patapsco Road, Finksburg, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 08/25 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematory 4 □ Donation 5 □ Other (Specify) Alexandria, VA 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01191 Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part | Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** on hvomo /Medical Due to (or as a consequence of): Examiner later neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funerel Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, Physician/Medical 06251 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 DEctopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Hunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy performed 1 Yes 2 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 39502 WJL address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 3 Westminiter HD 21157 osain. 0 447 Main Street. Balt 32. Redistrar's Signature 31. Date filed (Month, Day, Year) 2006 Registrar

			1 - State Registrar		Ce	rtificate of l	Death		g. No.	28207
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	/Medi Examir		4a. Facility Name (If not institution, give	t Wayne Wi	шеу	4b. City. Town, or	Location of Death	ququs/	25, 200 4c. County of Deat	
	LAGIIII	ICI	72 Jesse Boyd C	·		E1kton		•	Ceci1	
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8	B. Date of Birth (Month, Day,	1	hplace (State or Foreign untry)
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	pue M		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary f sho	ō	Maryland Cecil		E1kton					1 X Yes 2 □ No
	r 28a	lec	10e. Street and Number	l		10f. Zip Code		10	g. Citizen of What Co	untry?
	th with	Funeral Director	72 Jesse Boyd C	ircle		21921			United St	tates
	r dea	Iner	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of Hi	spanic Origin? (Spec n, Mexican, Puerto Ri	ify Yes or No-	14. Race - Ame Black, White	
21215-0036	within 72 hours after death with the Marylend ene. then "natural", or items 23e or 28e-1 show in Medical Exercian could be invitibled	Completed by Fu	1 ☐ Never Married 2 [X] Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	o !	1□Yes 2Ū(No		,	Specify:	nite
<u>ب</u>	"natu	ete	15. Decedent's Edi (Specify only highest grad	ucation le completed)	(Give	dent's Usual Occupa	luring most of working	7	6b. Kind of Business/	Industry
12	withir ene. then	d m	Elementary/Secondary (0-12)	College (1-4or 5+	-)	DO NOT use retired	Truck Dri	wor	Trucking	
Q	Hygi Hygi other		17. Father's Name (First, Middle, Last)		110	ressionar	18. Mother's Name (ś
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ary	and h	-	19a. Informant's Name/Relationship (T	ype, Print)	19b. Maili	ng Address (Street a	and Number or Rural	Route Number,	City or Town, State, 2	Zip Code)
., ≥	and		Sheree Lambourne W	illey/Wife					Maryland 2	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Experient must be notified at ance.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,		Mountain Memorial	natory or other place V1eW	Septen 1, 200		oc. Location - City or Ocky Mount 'irginia	Town, State
Balt	permit. Depenta Imports eny inju		21. Signature of Funeral Service Licens	600 Lish					A. ton, Maryl	and 21021
68760,	hysician and physician and as the burial-transit	Aedical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	э.				_	Interval Between Onset and Death
P.O. Box	death cer e attendir ed for use	by Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 9 Unknown	Petal death 3 ime of death 5	Ectopic pregnancy Other (specify)	on in Part I	23a Did taha	23d. Date of deli Month	Day Year
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	r this	5	1. Yes 2 No 27. Manner of Death	1 ☐ Inpatien	t 2 ER/Outpatier		4 Nursing Home		ice 6 Other (Spec	cify)
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	To the Hospital or Attending Phywibin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.	edical C	29a Certifier (Check only one) Certifying Phy 2 Medical Exam	eicien: To the best of iner: On the basis of and manner state	examination and/or in	n conumed at the tim vestigation, in my op	e date and place, an inion, death occurred	o due to the cau I at the time, dat	ueo(e) and manner ac e and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	,		29c. License	number	290	d. Date signed (Monti	n, Day, Year)
	12		M. Fark 30. Name and address of person who c	as Momplet cause of de	7 ath (Item 23a) (Type.	D /	5314		August -	15,2006
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Г	Physicia	an	Decedent's Name (First, Middle, Last) BONNIE LOU YANCOSKIE		2. Date of Death Month	Day Year 23 2006 0700 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	0	23 2006 0700 A M 4c. County of Death
1	Lxdillill	-	5901 Taylor Landing Rd.	Girdletree		Worcester
	. Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y 03/28/19	
Ľ.	Director		175 – 34 – 8547 Usual Residence of Decedent		03/28/19	942 <u>Pennsylvania</u>
	yland		10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits
	Ba-f s	ctor	MD Worcester Girdletre	ee		1 ☐ Yes 2 🔀 No
	with the	Funerai Director	10e. Street and Number	10f. Zip Code		g. Citizen of What Country?
	death ms 23	erai	5901 Taylor Landing Rd. 11. Marital Status 12. Was Decedent Ever in U.S. 13. W	21829 Vas Decedent of Hispanic Origin? (Spe		USA 14. Race - American Indian,
9	after or Iter	Fun	Armed Forces? If 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 █ No	/as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto ☐ Yes 2 No Specify:	Rican, etc.)	Black, White, etc.
003	ural',	d by	3 Wildowed 4 Molivorced Year or Dates:			Specify: White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. kthar than "natural", or Items 23c or 28a-f show ant, the Modical Examinar cust be molified at	Completed	(Specify only highest grade completed) (Give k	ent's Usual Occupation ind of work done during most of worki O NOT use retired)	ng 16	6b. Kind of Business/Industry
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Maryland	should be nd Mental marked c	2	Edward Noll		nennesey	27
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imo	Pages nent of I ant: If its ary or o			Crematory 8/24	1/2006 S	alisbury, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23c or 28a-f show any injury or other traumatic avant, the Modical Examination with the Indiana once.		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility Ho	lloway Fu	neral Home, P.A.
	20 7 g a		23a. Part1. Enter the disease, or complications that caused the death. Do not enter	3 Linden Ave., Po		
	emer.		shock, or heart failure. List only one adds on each line. Immediate Cause (Final	17 I	i respiratory arres	Interval Between Onset and Death
1	/Medical		disease or condition resulting in death) a. Que to (of as a consequence of):	(alove)
	Examiner		Sequentially list conditions b. LIWIL COST	uction WWW	rong (1)	llesse,
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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8760,	cate be executed physician and the burial-transit		d			
9	ing ph	Physician/Medical	IF FEMALE:			
Вох	death certifica e attending ph id for use as th	ian/	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy		23d. Date of delivery Month Day Year
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s, D	The law requires that the ste has been signed by th cage 2 should be detache	by Pt	Part II. Other significant conditions contributing to death but not resulting in the unconditions	derlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
ord	w require been sig				1X Yes	2 No 3 Probably 4 Unknown
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Vital F		e Col	OF Western day of the		performe	d? death? No 1 Yes 2 No
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סר	Attending Physician: ir death. actor: After this certific by the funeral director.		27. Manner of De th 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. es ibe how	_ '' ''
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Division of	l or Attending after death. Diractor: Atter I in by the funer	Certification:	4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm, streed building, etc. (Specify)	et, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	Hospital 24 hours a Funaral l		29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death	occurred at the time, date and place, a	and due to the caus	se(s) and manner as stated.
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	To the within 2 To the complet	Σ	29b. Signature and tittle of certifier	29c, License number	29d	Date signed (Month, Dey, Year)
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E	T 3		30. Name and address of burson who completed cause of death (Item 28a) (Type, P	Guy Drive is	rdin	ms 21801
	Sta		31. Date filed (Month Day, Year) AUG 2 3 2006 32. Jegistrar's Signature	antes		
	Registr	ar	TOUR O FORD THE PARTY OF THE			

01/06

State Registrar 31. Date filed (Month, Day, Year)



DR. RENU GUPTA M.D.

30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

AND REWS

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 860 10-12-06 vt. State of Maryland / Department of Health and Mental Hygien 2006

28210

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dorothy Ainsley **Physician** 29, Anisley 2006 Dorothy August 9:00A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kensington Nursing Home Kensington Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Fe D 24 + 1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 TF 218-18-8627 81 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene at the state of 15 and 18 a MD N/A 1 Yes 2 □ No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2340 Fleet Street 21224 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Yes 2 No
If Yes, Give X
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Myslak Margaret Skalinski 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m sny injury or other traum once. Sharon Long - Niece 3230 Elliott St. Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State 4 ☐Donation 5 ☐ Other (Specify) Bayview Crematory 9-1-06 Baltimore, Maryland 22. Name and Address of Facilit aczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, Md 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Physician Sudden /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown certificate has been signed by i rector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 [XNo 2 X No 1 — Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; the Hospital or Attending Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours e LIX Cartifying Physiciam: To this best of my knowledge, death occurred at the time, date and plane, and due to the nauce(e) and mainter as etated 29a Catther Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) WO D 23256 tupest 31, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAPHNE Hen ms 2309 Shorefreld hoad (wheater, ms, 2090) 31. Date filed (Month, Day, Year) 32 Degistrar's Signature State SEP 0 7 2006 Registrar 7000

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006

1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)_ 2. Date of Death 3. Time of Death Month Day Year **Physician** 25 P M BRUG ORMA 2006 66 /Medical 4c. County of Qeath Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL BAUTHORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec . 12, 1 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F 212-28-6328 74 Director 1931 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show other traumatic avent, the Madical Examiner must be notified at 1 TyYes 2 ☐ No Director 28a-f Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or Itema 23a 21230 United States 204 E. Fort Ave. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Be Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 years Cashier Grocery Store n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil tment of Health and Mental H tent: If Item 27 is marked off jury or other traumatic even ဂ္ Doris Bafford Frank McCready 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vickie DENINE Krakowski (daughter) 204 E. Fort Ave. Baltimore, MD 21230 Baltimore, 20a. Method of Disposition
1. □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Department of Importent: If any Injury or once. Meadowridge Mem. Pk. 9-9-2006 Elkridge, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fyreral Fervice Line 22. Name and Address of Facility McCully-Polyniak Funeral Fome, P.A. 130 E. Fort Ave. Baltimore, MD 21230 J. Wayne Osterling Pirt1. Ente disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or latiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fir al disease or addition resulting in death) SEMA **Physician** MPH /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): of Vital Records, P.O. Box 68760, for use IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24a. Was an autopsy performed? 1 ☐ Yes 😂 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To this hours after death.

Ineral Director; After this y filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 J Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) completely within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 30. Name and add 353 of person who completed cause of death (Item 23a) (Type, Print) OFEPH PLACE BANTHORE 301 ST 32 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 7 2006 Registrar

State of Maryland / Department of Health and Mental Hygien 2006 28212 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) BRENDLE Month 09 2000 V() M MARIE **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NE ARUNDEL MEDICAL CENTER If Under 24 Hrs. 8. Date of Birth Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b County 10c. City, Town or Location 10a State or 28e-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No NANICOKE Director 10e. Street and Number 10g. Citizen of What Country? 1.0.Box 1 21840 U.S.A. or items 23a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify MITE 3 Widowed 4 □ Divorced "natural" 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Decedent's usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) tomemaker L 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be should be find Mental I ELSIE I. ROSINSON DILLIAM STERLING 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print)permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 le rr any injury or other traum once. -BOX ISI NANICOKE MD. 21840 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State GIENHAVEN CEMETERY 9-9-06 5 Other (Specify) ` 4 □ Donation 21. Signature of Euneral Service Dicensee 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 23a. Lart1. Enter the disease, or work lication. It is a few fine death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death EMMON Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. I ed by the a 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 3 ☐ Probably 4 ØUnknown 2 🗆 No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has 2 No 1 ☐ Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ♣Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 No 0 After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death Certification: Injury Hospitel or Attending 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide filled in by determined 4 Homicide 16 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) Name and address of person W 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

State of Maryland / Department of Health and Mental Hygien 200628213 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Bennett Marian Sept 4, 2006 12:35 P [™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Beverly Health Care Center Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 9. Birthplace (State or For Pop) 7. Age (In yrs. last birthday) **Funeral** North Braddock Months Days Hours 1 M ATT 577 38 8229 92 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d, Inside City Limits or 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 □ Yes 2 □No Director Maryland Prince George's Clinton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 7506 Clinton Vista Lane 20735 United States or itama 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give — Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", or ital 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No δ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Accountant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Richard Cox Nellie Crow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha W. Guard (Daughter) 4205 Springview Court, Jefferson, MD 21755 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of Hi
Important: if iter
any injury or oth 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery Sept 8, 2006 Suitland, Maryland 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** tailure montan disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Dementa if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit be executed Box 68760, C Due to (or as a consequence of): attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the Part II. Other significant conditions contributing to death buf not resulting in the underlying cause given in Part I. 23e. Did tobacco use confinbute to the cause of death? Š pertension 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one, Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred After 1 Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funeral Director; completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the t 29c. License number 29d. Date signed (Month, Dey, Year) W Dein 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEM N ω . 610 Ninty 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2005 SEP 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006

			1 - For State Registrar 1. Decedent's Name (First, Middle.)			epartme Certifica			Mental Hy	Reg. No.	06 28214
	Physici /Medio Examin	cal	Mildred B 4a. Facility Name (If not institution,			4b. Cit	y, Town, or l	ocation of De	Month,	Day	Year 3. Time of Death CDC6 ILL PM of Death
	Funeral Director		University of Mo	ryland Medica	In yrs. last birt			If Under 24 H Hours Mi	n (Month Da	N /A th ay, Year) 9, 1934	9. Birthplace (State or Foreign Country) Maryland
	Maryland -f ehow	lor	Usual Residence of Decedent 10a. State 10b. County Maryland	N/A	10c. City, Town	or Location	Ва	ltimore		1	10d. Inside City Limits 1 Tyes 2 No
	h with the 3a or 28a st be notifi	ai Direc	10e. Street and Number 2456 Nevada Street			10f. Z	ip Code	21230		10g. Citizen of W	Vhat Country? U.S.A.
980	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Department of Heelth and Mental Hygiene. Important: If them 27 is marked other than "naturel", or itema 23a or 28a-f ehow eny injury or other treumatic event, I'm Medical Examinar must be notified at ODGe.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? d 1 □ Yes 2 □ No If Yes, Give Year or Dates:				panic Origin? , Mexican, Pur Specify:	(Specify Yes or No erto Rican, etc.)	14. Race Blac Specify	e - American Indian, k, White, etc. :: Błack
21215-0036	i within 72 ho jiene. r than "natur Ita Medical	ompieted	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 12	Education grade completed) College (1-4or 5+)		Decedent's Us (Give kind of v life. DO NOT	vork done du use retired)	ion iring most of w sewife	vorking	16b. Kind of Bu	siness/Industry Own Home
Maryland	uld be filed Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, L Harri	son J. Butler			1	18. Mother's N	ame (First, Middle M a	, Maiden Sumamary V. Simms	
, Mar	and 2 sho selth and I n 27 te ma er treums		19a. Informant's Name/Relationshi Frank Burgess Husb			2456 N	evada St	treet Baltin	Aural Route Numb more, Marylar		State, Zip Code)
Baltimore,	Peges 1 ament of He tant: if item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Domation 5 ☐ Other (Sp.	ecify)	20b. Place of cometer, Garriso	n Forest V	eterans/	Cemetery	Date 09/12/06		City or Town, State ings Mills, Md.
Ball	Depart Import eny in		21. Sign ture of Funeral Service	1. ESTEN	42		1300 Eu	others Fu taw Place	neral Service Baltimore, M	d 21217	
	nysician /Medical Examiner	. , , , ,	23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nty one cause on each line.	ac Ar	rhithn			acorrespiratory a	rrest,	Approximate Interval Batween Onset and Death
8760,	ate be executed thysician and the burial-transit	icai Examiner	Sequentially list conditions, if any leading to move data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a of the dot) Due to (or as a of the dot)		d:					
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rds, P	w requires that the de been signed by the c should be detached	ρ	Part II. Other significant condition	s contributing to death but	not resulting in	the underlying	cause given	in Part I.	1	5.2	ibute to the cause of death? 3 Probably 4 Unknown
Division of Vital Records,	i: The law re icete hes ber r, page 2 sho	Completed			200-21				24a. Was auto perfo 1 - Yes	DSV D	Vere autopsy findings available rior to completion of cause of leath? □ Yes 2□ No
\frac{1}{2}	Pnysicion: Ine this certificete hi al director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 ☐ ER/Out	patient 3 🗆 🛭	Othor		eath Check only of Home 5 Resi		er (Specify)
sion o	ending Phesath. or: After the	ertification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	tion	/ear) 28b. T	ime of ijury M	28c. Injury a Work? 1 ☐ Ye	at es 2□No	28d. Describe	how injury occurre	ed
É	2 4 4 5	Certific	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place of injury building, etc.	(Specify)				City or To	wn, State)	er or Rural Route Number,
:	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 ☐ Certifying (Check only 2 ☐ Madical E	Physician: To the best of caminer: On the basis of each manner state	xamination and	death occurre	d at the time on, in my opii	, date and pla nion, death oc	ce, and due to the curred at the time,	cause(s) and mar date and place, a	nner as stated. and due to the cause(s)
	To t	Σ	29b. Signature and title of certifier			2	9c. License				(Month, Dey, Year)
(₹		30. Name and a dress of person w	ho completed cause of dea			13-11			Sept.	5,2006
4.	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 7	2006 32. Høgistrar	s Signature	for Ell	i cott	Cifmi	D 51013		

State of Maryland / Department of Health and Mental Hygien 2006 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First Middle Last) Month Day **Physician** 3, 04:55 PM Edward Biernat 2006 September /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 105 Dinsmore Avenue Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 21, 1936 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** Months Days Hours 123M 2□F Yrs. 70 217-30-3881 MD Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 105 Dinsmore Avenue 21061 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Peges 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
Int: If itsm 27 is marked other than "natural", or ite ury or other traumatic avent, the Madical Exemine. 1 Never Married 21 Married 21215-0036 white 1 ☐ Yes 2X No Specify: Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 General Manager Restaurant Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stanley Biernat Rose Slokowski ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Lorraine Biernat /wife 105 Dinsmore Ave.; Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State September 1 Burial 2 □ Cremation 3 □ Removal from State permit. Pege Department o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) St. Stanislaus 9, 2006 Baltimore, MD 21. Signature of Furieral Sovice Licensee 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ancer **Physician** /Medical Due to (or as a consequence of) Examiner cm1 Sequentially list conditions, it any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ò in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 les 2 □ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 100 of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes / 2 No Certification: To 5 esidence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 tural 5 Pending investigation s after de-rel Director: Altr 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours 29a. Certifier 1 Pritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainteness as a place.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical within 2. To the 29e bicense number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier and address of person wbo/completed cause of death (Item 23a) (Type, Print) unhort hand may 31. Date filed (Month, Day, Year) State SEP 0 7 2006 Registrar

			1 - For State Registrar		State of	f Maryla	ind / Dep <i>Ce</i>	artment ertificate	of Health of Deat	and M		Reg. N		06	28216
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of Month				ay _	3. Time of Death	
	/Medio		Marjorie Madeline Beatty								sexemb	الال		900	10:15A.M.
	Examir	ner		a. Facility Name (If not institution, give street and number) Baltimore Washington Medical Center					4b. City, Town, or Location of Death			4	4c. County of Death		1 1
			5. Social Security N				center s. last birthday		n Burn		8 Date of Bir	th	Anne		
	Funeral Director		214-24-7	1	_M 2⊠F	r. Age (mr yr	81 Yrs.	Months		s Min.	8. Date of Bir (Month, Da 01-30-	-192	25	Coul WV	place (State or Foreign htry)
			Usual Residence of					1			02 00				
	yland		10a. State	10b. County		10c.	City, Town or I	Location						1	10d. Inside City Limits
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>		ia	304 De	elaware Av					21060				S.A.		
21215-0036		by Funeral Director	11. Marital Status 1 ☐ Never Mare 3 ☐ Widowed	ried 2⊠ Married 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 (∑No If Yes, Give Year or Dates:			. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2图 No Specify:			Rican, etc.) Rican, etc.) Rican, etc.) Rican, etc.)			e-American Indian, k, White, etc. : white	
5€ 5-0		ted	15. Decedent's Education 16a. Decedent's Us (Specify only highest grade completed) (Give kind of v						t's Usual Occupation 16th				b. Kind of Business/Industry		
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To Manyland				lame/Relationship (:1es A. Be	**	uichan			re Ave.						Code)
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MAR altimore,			1. Burial 2	☐Cremation 3 ☐				position (Name rematory or oth		1					
⋛≣	it. Partime		4 Donation 5 Other (Specify) Glen Haven Mem. Park 09-09-2000												
Ba	perm Depa impo eny i		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061												
	_		232 Part Fotor the disease or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest. Approximate												Approximate
	Dharistan		shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final												Onset and Death
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Вох	leath certific ettending p	Physician/M	23b. Was decedent pregnant in the past 13 months? 23c. If yes, outcome of pregnancy 1									23d. Date of delivery Month Day Year			
o.	at the de by the e tached t	ysic	1 ☐ Yes 2 9 ☐ Unknow	No	4⊟ Pregn 9⊟ Unkno		or death s	i□ Other (spe	спу)						
P.O.	Attending Physician: The law requires that the death certifics or death. •ctor: After this certificate has been signed by the ettending pt by the funeral director, page 2 should be detached for use as the	F.	Part II. Other sign	ificant conditions of	ontributing to de	eath but not	resulting in the	underlying ca	use given in Pa	art I.	23e. Did	tobacc	o use contr	ibute to t	he cause of death?
ds,		d by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								1 Yes 20 No 3 Probably 4 Unknown				
ö		ete									24a. Wa	s an	24h V	Vere auto	opsy findings available
Rec	The lav	Completed									auto perf	psy ormed	? 8	rior to co eath?	empletion of cause of
<u></u>	in: Th tificete or, pag	င္ပ	25 Was assa sata	erred to medical					00.0	lana of Death	1 Yes	/	No 1	☐ Yes	2□ No
Division of Vital Records,	ysician is certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No												(v)
o	g Phy ar this aral d	F	27 Manner of Dea	1		of Injury th, Day Year			lc. Injury at Work?		28d. Describe				
o	th. : After	ig ig	Natural 2 Accident	5 Pending investigatio		tn, Day Year) Injury	м	Work? 1 ☐ Yes 2	2 □No					
<u>is</u>	Attendi	100	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, st						office					er or Rur	al Route Number,
á	al or s afte il Dire	Certification:	4 Homicide determined building, etc. (Specify)								City or Town, State)				
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	To t To t	Σ	29b. Signature an	d title of certifier		^		29c.	License numb	190		29d. I	Date signed	t (Month,	Day, Year)
			P \$\square\$	6/16		M			1439	77		4	embe	1	4 2006
1	0		30. Name and add	dress of person who	completed caus	se of death (rem 23a) (Typ	e, Print)	11	3	~			1.1	· · · · · · · · · · · · · · · · · · ·
_	7		Junka	Glierum	p.30	17030	TO D	erre 1	Wan!	nun	e Ma	N)	210	61.	
		ate	3Y. Date flied (Mo			legistrár's Si	gnature								
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State of Maryland / Department of Health and Mental Hygiene 2006

28217

				C	ertificate (of Death		Reg. No.		
		1. Decedent's Name (First, Middle,	Last)				2. Date of I	Deeth Dev	Year	3. Time of Death
	Physician	Ruth Estelle Bu	tschky					03/2006	I bai	05:15 AM
	/Medical Examiner	4e Fecility Neme (If not institution,				4b. City, Tov	vn, or Location of De	eth 4c. County	of Deeth	
- Alba	Laminer	Future Care Che	saneake			Arno	1d	Anr	ne Aru	ındel
	Funeral			(In yrs. lest birthd	(ay) If Under 1 Y			Birth Yearl	9. Birthp	lace (State or Foreign
	Funeral Director	216-01-4362	1□M 219 F	90 Yrs	Months Da	ays Hours	Min. (Month, 11/1)	1/1915	Count	B
		Usual Residence of Decedent								
	fand	10a. Stete 10b. County		10c. City, Town o	r Location				10	0d. Inside City Limits
	Mary To	MD Anne	Arunde1	Glen H	Burnie					1 ☐ Yes 2X No
	ith the Mai or 28a-f s be notified	10e. Street end Number			10f. Zip Coo	de		10g. Citizen of	What Coun	try?
		14 Proctor Aven	110		210	61		U.S.A	A .	
	fler death v	14 Proctor Aver	12. Was Decedent E	ver in U.S.			nin? (Specify Yes or I		ce - America	an Indian,
	P P P	1 Never Married 2 Marrie	Armed Forces?		If Yes, specify	Cuben, Mexican,	pin? (Specify Yes or I Puerto Rican, etc.)		ck, White,	
20	al', or	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	•	1 ☐ Yes 2 🖾	No Specify:		Specif	white	2
Ş	houn train	15. Decedent		16a De	ecedent's Usual O	ccupation		16b. Kind of B	susiness/Inc	dustry
5	ed within 72 hor ygiene. For than "natura it, the Medical is	(Specify only highest	grade completed)	(G	ive kind of work do e. DO NOT use re	one during most etired)	of working			,
7	within than than the Mee	Elementary/Secondary (0-12)	College (1-4or 5-	+)	lomemaker			Own I	Home	
7	Hygiene. Thysiene. Ther than ant, the M	12 17. Father's Neme (First, Middle, L	est)	1	Iomemaker		r's Name (First, Midd	1		
ŭ	B sag						ra Dayton			
ž	should be to marked of umeric eve	Norman Wingate		- 1				-har City or Town	Ctata Zia	Code
Ja	AL 92 97 48	19a. Informant's Name/Relationsh					r or Rurel Route Num			
4	s 1 and 2 if Health item 27 i	Mr. Roger N. Bu	itschky / so		901 Wn19 isposition (Name o		Ridge Lan	20c. Location		
Baltimore, Maryland 21215-0020	S to L	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from State	cemetery,	crematory or other	place)		20c. Location	- City of 10	iwn, State
Ĕ	permit. Peges Depertment of Important: If its any Injury or o	4 □ Donation 5 □ Other (Sp		Louder	n Park Ce		09/09/ 2006	Balti		
alti	pemit. Peg Depertment important: I any Injury o	21. Signature of Funeral Service L	icensee	,			Singleto			
m	Dep impo	1 2011	1///	M01357	1 Second	l Ave SW	; Glen Bu	rnie, MD	2106.	1
		23a. Pert1. Enter the disease, or shock, or heart failure. List of	complications that caused	the death. Do not	enter the mode of	dying, such as	cardiac or respiratory	arrest,	1	Approximate
*	Di distan	shock, or heart failure. List o	only one cause on eech lin	Θ.		, -			i	Interval Between Onset and Death
	Physician /Medical	Immediate Cause (Final	Dna	Iman	2				į	1000
	Examiner	disease or condition resulting in death)		Lmon					-	day_
	- I	,	~~	Due to (or as a cor	nsequence of):				1	1100,00
/	n and iel-transit		· Den	pentre	\sim					years
	certificeta be executed ding physicien and use as the buriel-transit	Sequentially list conditions,		Due to (or as a cor	nsequence of):					
68760,	Se es	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c							
87	the	that initiated events resulting in death) Last	ľ	Due to (or as e con	sequence of):				1	
9	certificeta be ding physicie ise as the bu								i	
Вох	- c - L		U .							
	The lew requires that the death of the attential has been signed by the attentiage 2 should be detached for unpage 2 should by Physiciar Completed by Physiciar	Part II. Other significant condition	as contributing to death bu	t not resulting in th	ne underlying caus	e given in Part I.	23b. D	id tobacco use co	ontribute to	the cause of Geath?
P.0	by the						1	☐ Yes 2☐ No	3 ☐ Prol	bably 4 ☑ Unknown
	igned be de								-	
of Vital Records,	v require been si should t							as an autopsy informed?	ava	ere autopsy findings ailable prior to
8	The lew require sate has been si page 2 should Completed									mpletion of cause death?
Re	The lev						1[☐Yes 2∰No	1[∃Yes 2□No
a		25. Was case referred to medical				26 Place	of Beath (Check on	¥		
₹	Physician: this cartific ral director,	examiner?	Hospital:		otiont 3 DOA	Other:	rsing Home 5 Re		hor (Specif	id
ð	Physic this car al dire	1 Yes 2 No	1 ☐ Inpatie					e how injury occu		y/
2	Br fa o	1 Natural 5 ☐ Pending	(Month, Dey		M M	Injury at Work? 1 ☐ Yes 2 ☐ I				
Si	Attending or deeth. ector: Aftar fune by the fune tiffication	3 ☐ Suicide 6 ☐ Could n	ot be Ope Place of Inju	iry - At home, farm				n (Street and Num	ber or Rura	al Route Number.
Division	tal or Attending P is efter deeth. al Director: After ted in by the funers Certification:	4 ☐ Homicide determi	building, etc	. (Specify)	, 311991, 1401019, 01	1100		Town, Stete)		
	urs e	On Cartification and Assess	District Total Control	f mu to and a decorate	leath conversed of the	no timo data	d place, and due to the	ne seuco/s\ sed =	20000000000	tated
	To the Hospital or Attendit within 24 hours efter deeth. To the Funeral Director: A completely filled in by the ti	29a. Certifier 1 Certifying (Check only 2 Medical E	Phyeician: To the best of xaminer: On the basis of	exemination end/o	eatri occurred at the or investigation, in	my opinion, deal	u place, and due to the time to the time.	e, date and place	, and due to	the cause(s)
	within 2. To the F complet	one)	and menner sta	ted.	200 11	cense number		29d. Date sign	ed (Month	Dev. Year)
	With To	29b. Signature/and title of certifier	11	1 -1	1)	5/	カフコビ	Cod. Date sign	the property of	00/
					TO	000	100	7-6	- X	006
	2	30. Name end address of person v	who completed cause of de	eath (item 23e) (T)	pe, Print)	11.	abore A	1-11	11	101 21110
		Jenniterkie	dinger	8601 V	etera.	ns ///	ghway/V	· Wers	Ville	MALIOR
	State	31. Date filed (Month, Day, Yeer)	32. Registra	ır's Signature						
	D	CED O P	2000	-						

Physic	ian	Decedent's Name (First, Middle, Last	Roy	2/06 Jh 2/06 Jh Burroughs		2. Date of Death Month	Day Year	3. Time of Death
/Medi	cal	4a. Facility Name (If not institution, give	street and number)	4h C	ity, Town, or Location of Dea	SEPTEM	4c. County of Death	86 2:20 MA
Exami	ner	Saint Josep				owson	·	ltimore
Funeral Director		5. Social Security Number 22020-0967 Usual Residence of Decedent		Yrs. Iast birthday) If Un Monti	der 1 Year If Under 24 Hr ns Days Hours Mir		9. Birthp Coun	laca (State or Foreign try)
Maryland -1 show fled at	tor	10a. State 10b. County	A 2	City, Town or Location	nore		1	0d. Inside City Limits
3a or 28a	I Director	10e. Street and Number	son Are	10f.	Zip Code 212.17	10g	Citizen of What Coun	iv?
d within 72 hours after death with the Maryland plene. I then "netural", or Items 23s or 28s-1 show the Medical Exam her must be positied at	by Funeral	11. Marital Status 1	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	If Yes, s	cedent of Hispanic Origin? (pecify Cuban, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - Americ Black, White, Specify:	
within 72 hour ene. then "natural' the Medical Ex	Completed b	15. Decedent's Ed. (Specify only highest grade Elementary/Secondary (0-12)			sual Occupation work done during most of w use retired)	orking 16	b. Kind of Business/Ind	dustry tor,
al Hygiene I other the vent, the	Be Com	17. Father's Name (First, Middle, Last)	1		18. Mother's No	ame (First, Middle, Ma.	Speciali iden Sumame)	ist
2 should be fill and Mental H Is marked ott eumatic even	To	19a. Informant's Name/Relationship (7)	erough:		ess (Street and Number or R	Gural Boute Number O	Gerry Dity or Towit State Zio	Code)
and salth n 27			roughs, Dao	9.3762 T	Bonview A	re. Ba 170). MD 2	1213
permit. Pages 1 Department of He Important: if iter any injury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,	Removal from State	Place of Disposition (in cemetery, crematory)	or other place)	3060	wing Mi	1k, MD
permit. Depart Import any inj		21. Signature of Funeral Service Licens	owell Sr		and Address of Facility -		To Mo	110me 21207
hysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	lications that caused the de one cause on each line.		node of dying, such as cardi	ac or respiratory arrest		Approximate Interval Between Onset and Death
/Medical Examiner		disease or condition resulting in death)	Due to (or as a cons	equence of):				
	Jer	Securitially list conditions if any, leading to immediate	b. Due to (or as a cons	equence of):	TUS ULCER			
death certificate be executed e attending physicien and of for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cons	equence of):				
eath certificate latendad	/Medic	IF FEMALE:	23c. If yes, outcome of preg	anancy.	,,,,,	2011-11-11-1	004 Date (44)	
thet the death of the death of the detached for un	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3 □Ectopi	c pregnancy (specify)		23d. Date of delive Month	Day Year
Se og	by	Part II. Other significant conditions co	-	resulting in the underlyin	g cause given in Part I.	23e. Did tobac	cco use contribute to the	ne cause of death? ably 4 □Unknown
e law has b	Completed	ANEMIA				24a. Was an autopsy performe	prior to cor	psy findings available inpletion of cause of
Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			eath (Check only one)	· · · · · · · · · · · · · · · · · · ·	
Phys raths raths	To To	1 ☐ Yes 2 📉 No 27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at	Home 5 Residence	ce 6 Other (Specify	/)
Attending Ph r death. ector: After th by the funeral	cation	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)) Injury M	Work? 1 ☐ Yes 2 ☐ No			
5 g 5 5	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, street, fac ecify)	tory, office	28f. Location (Stree City or Town,	et and Number or Rura State)	I Route Number,
Hospit 4 hour Funer ely fille	ledical C	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	/sician: To the best of my kiner: On the basis of examinant manner stated.	knowledge, death occurrination and/or investigat	red at the time, date and pla- ion, in my opinion, death oc	ce, and due to the caus curred at the time, date	se(s) and manner as st a and place, and due to	ated. the cause(s)
To the within 2 To the complet	×	29b. Signature and title of certifier			29c. License number	29d	. Date signed (Month,	Day, Year)
			Kan		D 37254		9-4-06	3
0								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [9] [] [5] 28219 1 = For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Frank Joseph Cascio 11:45 A M September 2,2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8 Mariners Walk Way Baltimore Middle River If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 13, 1933 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 XM 2 ☐ F 213 30 8758 72 Yrs Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "naturel", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Maryland Harford Edgewood Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2007 Magnolia Woods Ct. ("Apt" B.) 21040 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give 1951/54 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Analyst Steel Mill 12 permit. Pages 1 and 2 should be file Department of Health and Mentar Hy Important: If Item 27 is marked otherny injury or other treumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles J. Cascio Estelle M. Malinowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlene M. Douglass (Daughter) 8 Mariners Walk Way Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 9/8/2006 Garrison Forest, Marylan 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lipansee 22. Name and Address of Eacility Bruzdziński Funeral Home P.A. Se lade 1407 Old Eastern Avenue Essex, Maryland 21221 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Approximate Interval Between Onset and Death one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Malignani reta static 5months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 1 Yes 1 Yes 2 No 2⊠No 25. Was case referred to medical examiner? 26. Place of Death | Check only one 5 □ esidence 6 Mother pecify) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 XNo Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 XNatural s after de-ral Director: Aft to the fo 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a To the Funeral C XI

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Box 68760,

P.0.

Division of Vital Records,

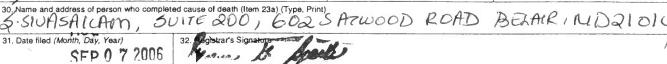
State Registrar

31. Date filed (Month, Day, Year) SFP 0 7 2006

luasallam

29b. Signature and Mile of certifier

·SIUASAICAM



29c. License number

D45530

29d. Date signed (Month, Day, Year)

			For State Ragistrar	State of Marylan	d / Depa <i>Cer</i> i	rtment of H	ealth and Death		giene Reg. No.	2006	28220
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		3. Time of Death
	Physici: /Medic		Raymond Geo	orge Cu	trell			Month	Day	2000	7:51 PM
	Examin		4a. Facility Name (If not institution, give s	reet and number)	/	4b. City. Town, or	Location of Dea	th	4c.	County of Deal	more
ā	Funeral Director		5. Social Security Number 6. Sex 212-40-1851	7. kge (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h y. Ye <i>ar)</i> 1943	9. Birt Co V 1 1	hplace (State or Foreign ountry) rginia
	D .		Usuel Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Loc	ation					10d. Inside City Limits
	anyla ho	5		_		ation					1 ☐ Yes 2 No
	286-1	Director	Maryland Baltimo	re Es	sex	10f. Zip Code			10a. Citi	zen of What Co	ountry?
	3a or		18 Sidewell Court			21221				S. A.	
	ms 2	Funeral		12. Was Decedent Ever in U.	.S. 13. W	as Decedent of H	ispanic Origin? (Specify Yes or No-		14. Race - Ame	
336	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28e-f show aumatic event, the Madical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		Yes, specify Cuba ☐ Yes 2 No	Specify:	to Alcan, etc.)		Black, Whit Specify:	e, etc. White
Maryland 212/15-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grade		16a. Deced	ent's Usual Occupa	ation	orkina	16b. Ki	nd of Business/	Industry
<u> </u>	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired)	, King			
2	filed withii Hygiene. other than ent, list M		10		Drive	er	10 Mathada Na	me (First, Middle,		ucking	
and	d be fi	Be	17. Father's Name (First, Middle, Last)	11				_		Surname)	
2	hould d Me mark matic	۴	Raymond Cutre 19a. Informant's Name/Relationship (Ty		19b. Mailine	Address (Street a	Ruby	Dunnay		r Town. State. 2	Zip Code)
<u>s</u>	nd 2 s lith ar 27 is r trau		Sharon Corzine (S			B Parker		arringto			
altimore,	f Hearlitern		20a. Method of Disposition	20b. P	lace of Dispos			Date		cation - City or	
Ë	Page nent o int: If		1	emoval from State		Ll Mem. C	9	/5 006	Bal	timore,	Maryland
Balti	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic evonce.		21. Signature of Funeral Service License		22	Name and Address 112dzinsk 107 Old E	ss of Facility				land 21221
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the deat					rest,	ny rary	Approximate Interval Between
)	Physician		Immediate Cause (Final disease or condition resulting in death)	Acute M	yo Can	dial =	Infar	ction			Onset and Death
	/Medical Examiner		Sequentially list conditions,	COPONALY		ery D	isease				
	led Isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):						
o Ô	cate be executed physiclen end ; the burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
8760,	ate be	dlcal		l							_
9 X	eath certific attending p I for use as i	a a	IF FEMALE:	3c. If yes, outcome of pregna	ancv					23d. Date of de	in one
Вох	death	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	Ectopic pregnancy Other (specify)			'	Month	Day Year
<u>о</u> .	thet the de ned by the a deteched f	hys	9 Unknown	9□ Unknown							
ds, F	8 5 8	اھ	Part II. Other significant conditions con	itributing to death but not res	ulting in the un	derlying cause give	en in Part I.	23e. Did to			o the cause of death?
Division of Vital Records,	ie law require has been sig ge 2 should t	Completed						24a. Was		24b. Were au	utopsy findings available completion of cause of
œ =	The sete h page	Sol						perfo 1 ☐ Yes	rmed?	death?	2 □ No
/ita	Iclan: sertific ector.	Be	25. Was case referred to medical examiner?	logoital:	,	. Oth		ath (Check only o	ne)		
 	Physic this c	P	1 ☐ Yes 2 No Cath	lospital: 1 ☐ Inpatient 2 X 28a. Date of Injury	ER/Outpatient 28b. Time of		4 🗆 Nursing	Home 5 Resid			city)
u o	ding h. After funer	ig E	1X Natural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injun Work	k? Yes 2 □ No	200. Describe i	iow injui	y occurred	
<u>is</u>	Attend death ctor: /	flca	3 Sutcide 6 Could not be	28e. Place of Injury - At h	ome, farm, stre						ural Route Number.
á	urs after real Dire	Certification;	4 Admicide	building, etc. (Specif				City or Tov			
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	(Check only	sician: To the best of my kno ner: On the basis of examina and manner stated.							
	To the within 24 To the Complete	ž	29b. Signature and fittle of certifier	MO		29c. Licens	number	596	29d. Dat	é signed (Mont	h, Day, Year)
•	10		30 Nam and address of person who ad	empleted cause of death (Item	n 23a) (Type, F	rim)		211-00	m	m	71230
	Sta	ite_	31. Date filed (Month, Day, Year)	32 Aegistrar's Signa	ture /	Square	N. D	altiriur	e,	ma	2110/
	Regist		SEP 0 7 200	O RECEIPED L	F ASSE	CERI					

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 2822

		1- For State Registrar			Ce	ertifica	ate of	Death					Reg. No.	21	JUC) (.026
Physicia	in/	1. Decedent's Name										Date of De Month	Dav	Yea		3. Time of	_
ledical Exami	ner	MICHA	EL E	ARL COTE	IRAN, JR	-		_				Septemb	er 4, 20	006		0857	hrs
		4a. Facility Name (if r Laurel Region		_	number)		4t	. City, Towr Laurel	n, or Le	ocation o	f Death			County or rince G		S	
Funeral		5. Social Security Nu	mber	6. Sex	7. Age (In yrs.	last birt	hday)	If Under 1		-		8. Date of E	Birth (MM/E	D/YYYY			ate or
Director		260-43-63	298	1 X M 2 F	28		Yrs.	Months	Days	Hours	Min.	July	25,	1978	Foreign Cour	^{ntry)} Ge(orgia
		Usual Residence of D			1												
w any		10a. State	0b. County				or Locatio										e City Limits
Maryland 28a-f show	ō	MD		jomery	S.	ilve	r Spi										s 2 XX ^{No}
Mary 28a-	Director	10e. Street and Numl	ber					10f. Zip Co	de				10g. Citiz	en of Wh	at Count	ry?	
th the Maryland 23a or 28a-f sho	⊡	3318 Par	kford					209					U.S	.A.			
ems 2	era	11. Marital Status 1 XXNever Married	1 2 M		ecedent Ever in l Forces?	U.S.		Decedent of s, specify Co					lo-	 Race White 		an Indian,	Black,
or dea	Funeral			1 XXYes orced If Yes, Give Y			4	res 2X	No	one sife			ı,	Specify.	Wh	ite	
rs afte	۵	3 Widowed 15. Decedent's Edu		or Dates:		16a 1		s Usual Occ			ind of wor	k done		ind of Bu			
2 hou "nat	Completed	Elementary/Secon			(1-4 or 5+)			st of working								ĺ	
215-0036 be filed within 7: ttal Hygiene. -ked other than ent, the Medical	힏			5	i +		Secre	et Ser	vi	ce A	gent		F	eder	al G	overr	nment
5-0 led wi tygie other	3	17. Father's Name (F	irst, Middle,	Last)					18	3. Mother	s Name (F	irst, Middle	, Maiden S	Surname)			
21214 Uld be fill Mental F marked	a	Michael			Sr.						yle M					(41.25	
21 should nd Me is mas	유	19a. Informant's Nam			/C +1	1.3		Address (S									
bre, MD 21215-0036 Is I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f she reraumatic event, the Medical Examiner, must be notified at once		Michael 20a Method of Dispo		nran, Sr				rmer F				oate				539-7 own, State	
Baltimore, Department of Hee Important: If ite				3 XXRemoval	from State	cremate	ory or othe	r place)		1					•		
timent Traint:		4 Donation 5			Ha	zleh		Memor				9/06			urst	, Geo	orgia
Baltimore permit. Pages a Department of He Important: If it		21. Signature of Fund	eral Service	Licensee	M00770		22. 50	malads 13 Tal	on on	Fund	eral	Home,	P.A	· Mare	-7.55	a	0707
Physician	-	23a. Part I Enter the	disease, or	complications that		th. Do no											mate Interval
/Medical	n 18	failure. List only	one cause	on each line.	d cardiom												n Onset and Death
Examiner		Immediate Cause (Fi or condition resulting		_	a consequence		119										
		Sequentially list con-		b													
	ine	if any, leading to imn	lying Clause	Due to (or as	a consequence	of):											
cuted and transit	Examine	(Disease or injury the events resulting in de		·	a consequence	of):											
760, cate be execut physician and he burial - tra	n/Medical	X UNPENDED		d. AMENDE	item#23	2 27	porMF.	~86A	10/1	17/06	TT i	tom#1 t	norME.				
8760, tificate be ex ng physician as the burial	e e	IF FEMALE:		23c. If ye	s, outcome of pre		perric	gow,	10/ 1	17/00	11 1	LCIIII 1 9]		. Date of	delivery		
687 Sertific Iding p	an/I	23b Was decedent p past 12 months?		LIVE				I death	3	Ectopic	pregnanc	у		Month	Da	àУ	Year
Box e death of the attenued for use	Physicia	1 Yes 2 No	9 Unl	(nour)	gnant at time of d known	death ₅	Oth	er (Specify)					100				
that the death certificated by the attending detached for use as!	٩ ج	Part II. Other signifi	cant condit			resulting	g in the ur	derlying car	use giv	en in Pa	rt I.	23e, Did	tobacco	se contri	bute to th	ne cause (of death?
, P.O.	ð											1 🗌 Y	es 2 🗸	No 3	Proba	ibly 4	Unknown
rds, requir been s	Completed											24a Wa					ngs available
e law	ם			-								per	opsy formed?	d	eath?	•	of cause of
tal Recting The certificate ector, page		25 Was case referre	ed to medica	1				26 F	lace r	of Death	Check on	1 Yes	2 No) 1	✓ Yes	2	No No
Vital Rec ysician: The his certificate director, page	o Be	examiner?		Hospital: 1	Inpatient 2	/ ER/O	utpatient			other 4		Home 5	Resider	nce 6	Other		
n of Vital Records, ding Physician: The law requir After this certificate has been s funeral director, page 2 should I	-	1 ✓ Yes 2 27. Manner of Death		28a. Da	te of Injury nth, Day, Year)		Time of In	-	Injury	at Work	? 28	Bd. Describ			ed		
on endin sath or: A	tio	1 A Natural	5 Pene	ding	nin, Day, tear)			1	Υe	s 2	No						
Division pital or Attendiours after death eral Director: Affilled in by the fi	iţi	2 Accident 3 Suicide		stigation 28e. Pl	ace of Injury - At	home, fa	arm, street	, factory, off	ice bu	ilding, et	c. 28	8f. Location or Town,		nd Numbe	er or Rura	al Route N	lumber, City
Dital ours a filled	Certification:	4 Homicide	dete	rmined (Special	(y)							Of TOWIT,	State)				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	edical (hysician: To the book	is of examination												
To To com	Mec	29b. Signature and ti	itle of certifig	and manne	r stated			29c. Li	cense	number			29d. [ate signe	ed (Mont	th, Day,Ye	ar)
		()	al	rleud				0	.C.N	1.E.			Sep	tember	5, 200	16	_
		30. Name and addre	ss of persor	who completed ca	ause of death (Ite	em 23a)		-									
	- 4	Laron Locke	MD. A	ssistant Medi	cal Examiner	11	1 Penn	Street, B	altim	ore, M	D 21201	1					
Si Regis	tate trar	31. Date filed (Month		2006	kegistrar's Signa	ature	Good	w									
1,0913	_	311.	- V	TANK IN	10000	-											

Carbaugh

7. Age (In yrs. last birthday)

Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min.

Days

Cheverly

2. Date of Death

Month

Day

4c. County of Death

Prince George's

U.S.A.

14. Race - American Indian, Black, White, etc.

Specify: White

Stee1

23d. Date of delivery

24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Month

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

9-5-06

CHEVERLY MD 20785

28d. Describe how injury occurred

September 4, 2006

Bernard

28222

5:23PM

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 ▼ No

9. Birthplace (State or Foreign

Hanover, PA

Certification: After deeth. Director within 24 hours after To the Funeral Direct cai 27. Manner of Death

1 🛮 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one) 29b. Signature

30. Name and add

- State Registra

Physician

/Medical

Examiner

Funeral

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

Philip

5. Social Security Number

DHMH 17 Rev 1/2001

State Registrar JAM KFKHAM-EBRAHIMI

5 Pending

investigation

6 Could not be determined

ess of person who completed cause of death (Item 23a) (Type, Print)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D59318

1 ☐ Yes 2 ☐ No

State of Maryland / Department of Health and Mental Hygiens 28223 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Sep 3, 2006 3:00 a George Η. Campbell, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner Baltimore** Future Care-Irvington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 9. Birthplace (State or Foreign **Funeral** Virginia Months 1 X M 2 □ F 230-44-1528 71 Aug 1, 1935 Director Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits worde i the Mudical Exacitive must be notified at 1 Yes 2 No **Baltimore** Maryland N/A Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 2521 Druid Hill Avenue-2nd floor 21217 U.S.A. or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. fited within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Factory Industry Elementary/Secondary (0-12) College (1-4or 5+) **Factory Worker** 12 t. Pages 1 and 2 should be filed vitment of Health and Mental Hygie trant: if Item 27 is marked other to jury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Agnes Campbell Isaac Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2409 Kermit Court Baltimore, Maryland 21230 George Campbell Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🗷 Removal from State permit. Page Department o Important: if any injury or once. 09/09/06 Lancaster, Virginia 4 ☐ Donation 5 ☐ Other (Specify) New Jerusalem Baptist Church 21. Sign Illers of Funeral Service License 22. Name and Address of Facility

Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** ASCVD /Medical Examiner alon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. cate has been signed by the page 2 should be detached 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification; To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an 1 ☐ Yes of Vital 2. No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₺ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division 12 Natural 5 Pending investigation after death.

Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined within 24 hours after de To the Funeral Directo completely filled in by the 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Cartifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET Ballimore MD 21201 A-AHMED 821 M. Eulaw 32. Signatura 31. Date filed (Month, Day, Year) SEP 0 7 boarde State 2006 Registrar

06-06528

Please Type or Print in Black Indelible Ink

Claude Cates State of Maryland / Department of Health and Mental Hygiene 2006 28224 1- For State Certificate of Death Reg. No. Registrar Physician/ 2. Date of Death Month Day August 31, 2006 **Medical Examiner** 1339 hrs CLAUDE JOE CATES 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3601 Gallatin Street #732 Hvattsville Prince George's 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of Days Hours Director 283-40-1311 Country)Kentucky 2 Dec. 2, 1941 1 X M 64 Usual Residence of Decedent any 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 No Prince George's Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene ant. If I filem 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Maryland Hyattsville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 3601 Gallatin Street, 20782 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black Armed Forces? 1 X Never Married Married White, etc. Yes 2 X No Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify. White ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Customer Service Food Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willard Claude Cates Hortense Hight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dianne Leung - Sister 11 Mason Road, Valatie, New York 12184 20a. Method of Disposition 20b Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 permit Pages
Department o
Important: I 9/4/2006 Metropolitan Crematory Alexandria, Virginia Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Line Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** ailure. List only one cause on each line /Medical Death Wypertensive athersoclerotic cardiovascular disease Immediate Cause (Final disease Examiner or of ndition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Physician/Medical physician a X UNPENDED AMENDED item#23a, 27, perME, 860, 10/24/06 TT Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day past 12 months? 2 Year Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? page this certificate Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Other 4 Inpatient 2 ER/Outpatient 3 מחם [Nursing Home 5 Residence 6 🗸 Other: Scene 1 V Yes ۵ 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Division hours after death 5 Pending Yes 2 No the 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined within 24 hours To the Funeral Homicide 29a. Certifier ical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 1, 2006 JA Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (MorSEPy, Yoar) State 2006

DHMH 17 Rev 1/2001 OCME 2006

Registra

	-	For Amend #1&18 P	State of Maryland / I er Phy &FH G85	Certificate	of Health and Me of Death	Heg	ene 2006	
Physicia /Medic		Decedent's Name (First, Middle, Last) RAYMOND	Bertram BETRAM	CLIFT	, JR.	2. Date of Death SEPTEME		3. Time of Death 06 7:22Р м
Examin		4a. Facility Name (If not institution, give structure) GILCHRIST HOSP		4b. City, ³	TOWSON		4c. County of Deat	IMORE
Funeral Director		5. Social Security Number 6. Sex 12XA	7. Age (In yrs. last bi		1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day,) 12-18-	9. Birti 1928 V	nplace (State or Foreign untry) 'IRGINIA
Maryland f ehow	or	Usual Residence of Decedent 10a. State	rimore 10c. City, Tow		EUDOWOOD			10d. Inside City Limits 1 ☐ Yes 2 No
with the Page or 28a-	Direct	10e. Street and Number 305 DONEGAL D	RTVE	10f. Zip	Code 21286	10	g. Citizen of What Co	-
be filed within 72 hours after death with the Maryland tal Hygiene. It has not been dother then "natural", or items 23a or 28a-f show event, the Maulcal Examinar must be notified at	d by Funeral Director	11. Marital Status 12 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Was Decedent Ever in U.S. Armed Forces? The 2 No If Yes, Give Year or Dates: WWII	If Yes, spec		Rican, etc.)	14. Race - Ame Black, White Specify:	e, etc. WHITE
within 72 h lene. Then "nate	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 12	Callage (1-Acr 5+)	a. Decedent's Usua (Give kind of wol life. DO NOT us BG GENEI	rk done during most of work se retired)	ng M	ID ARMY N	IATIONAL
2 should be filed within and Mental Hygiene.	o Be C	17. Father's Name (First, Middle, Last) RAYMOND B.	CLIFT, SI		JESSIE		(LLYC)D)
		19a. Informant's Name/Relationship (Type BARBARA CLIFT/W			(Street and Number or Run EGAL DRIVE		City or Town, State, 2 IOOD, MD	Zip Code) 21286
Pages 1 and nent of Health int: If Item 27 iry or other tr		20a. Method of Disposition 1 □ Burial 2X Cremation 3 □ Rei 4 □ Donation 5 □ Other (Specify)	moval from State	of Disposition (Namery, crematory or o	ther place)		Oc. Location - City or ${ t CATONSVII}$	
permit. Pages 'Depertment of H Important: If Ite eny injury or of		21. Signature of Funeral Service Licensee	l	22. Name an	d Address of Facility CV	ACH 'ROS	SEDALE FU SEDALE,	NERAL HOME MD 21237
death certificate be executed e attending physicien and ior use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	cause on each line.	NCEV e of):	e or gying, such as cardiac	or respiratory arre	91,	Approximate Interval Between Onset and Death WWW.S
ath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	th 3 ☐ Ectopic p 5 ☐ Other (s _p			23d. Date of de Month	livery Day Year
hat I	Ď.	Part II. Other significant conditions cont	ributing to death but not resulting	in the underlying o	ause given in Part I.			o the cause of death?
25 8 9	Completed					24a. Was ar autops perform 1 \subsection Yes 2	prior to	utopsy findings available completion of cause of s 2 2 No
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Attending Physician: or death. ector: After this cartilicuth tuneral director.	ion: To	27. Manner of Death	1 Inpatient 2 EHV		28c. Injury at Work? 1 Yes 2 No	28d. Describe ho		ecity) * Woy (&
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certilicate ha completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factor	y, office	28f. Location (St. City or Town	reet and Number or F , State)	lural Route Number,
To the Hospital within 24 hours a to the Funerel completely filled	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	icien: To the best of my knowled er: On the basis of examination and manner stated.	lge, death occurred and/or investigation	at the time, date and place n, in my opinion, death occu	, and due to the carred at the time, da	tuse(s) and manner a ate and place, and du	s stated. e to the cause(s)
To the P within 24 To the Complete	Me	29b. Signature and title of certifier	~~	29	c. License number	25	eptember	th, Day, Year) - 2 2006
11		30. Name and address of person who con	mpleted cause of death (Item 23a	a) (Type, Print) Charle.	ST BARM	oe up	21204	
St Regis	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature		2)			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200628226 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 5, 2006 **Physician** 6:20a M Harry C. Cook /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Columbia Howard Vantage House If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5/16/1916 6. Sex 1 M 2 ☐ F 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** West Virginia 578-10-9652 90 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked to ther than "natural; or Items 23a or 28a-1 show ury or other traumatic event, Ira Medical Expresse must be notified at 1 ☐ Yes 2 XNo Director Md. Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5400 Vantage Point Rd. 21044 USA by Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 □ No 1942-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 3 X Widowed 4 ☐ Divorced 1947 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Estimator Naval Research Lab 4415 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary M. Waywacker Christopher C. Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16125 Malcolm Dr. Laurel, Md. 20707 Dennis R. Cook/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o № Burial 2 Cremation 3 Removal from State 4 □Donation 5 □Other (Specify) Suitland, Md. Cedar Hill Cemetery 9/9/2006 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Fungral Service DDCe. MOO845 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) erel **Physician** Vers /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 50 Due to (or as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed seme physician the burial Box 68760, Physician/Medical as attending p IF FEMALE If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) by the a ☐ Yes 2 ☐ No. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No been signated 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an has autopsy performed page 2 this certificate 2 No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director; After 1. Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide To the Hospital filled 1🔁 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical pletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 1/2001

P.O. |

30. Name and address of person who completed cause of death (Kem 23a) (Type, Print)

2006

32 egistrar's Signature

31. Date filed (Month, Day, Year)

SEP 0 7

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 3:50PM September 3, 2006 Ralph Albert DeNardo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Davidsonville 1517 Manor View Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nonths | Days | Hours | Min. | April | Day 1 Year | 945 9. Birthptace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□F Washington DC Yrs. 219-42-4214 61 Director Usual Residence of Decedent with the Maryland 10d. fnside City Limits 10a, State 10b. Count 10c, City, Town or Location other then "natural", or items 23s or 28s-f show Davidsonville 1 Yes 2 No Maryland Anne Arundel Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21035 1517 Manor View Road filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 △ Yes 2 □ No 1965 − t Yes, Give Year or Dates: 1967 Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) Hygiene, 12th Day Trader Self-employed Pages 1 and 2 should be filed viment of Heath and Mental Hygie tent: if item 27 is marked other fury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Constance Nunziata Theodore DeNardo 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1517 Manor Road Davidsonville, MD 21035 19a. Informant's Name/Relationship (Type, Print) Mary DeNardo (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Sept. 8, 1 Barial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 2006 Marvland Veterans Cem. Cheltenham, Maryland 4 ☐Donation 5 ☐ Other (Specify) nerat Se 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signatura 6633 Old Alexandria Ferry Road Clinton, MD 20735 Approximate Interval Between Onset and Death 1 Month Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Metastatic Pancreatic Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine physician and s the burial-transit or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) .O. Box 68760. Completed by Physician/Medical use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4 Pregnant at time of death signed by the at d be detached to 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autopsy performed? t ☐ Yes 24 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of fnjury (Month, Day Year) After thi 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Naturaf 5 Pending 1 ☐ Yes 2 ☐ No death. Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by within 24 hours after of To the Funeral Direct completely filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier 2006 au D0029571 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2225 H Defense Sighway, Crofton, Maryland 21114 Berez, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar EP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? 106

			1 - Manend #4b&c Per		706706 Jf	tificate of L	Death	Reg.	No.	28228
Н	Physici	an	1. Decedent's Name (First, Middle, Last					2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examir		4a. Fecility Name (If not institution, give			4h City Town or	Location of Death	٦	4c. County of Dea	13:38 M
	Examir	ier	Johns Hopkins Hosp		ew	Bathmare			USA	N/A
	Funeral Director		5. Social Security Number 6. Se 217-50-0673	7. Age (//	n yrs. last birthday) 9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye May 2 19	9. Bir	thplace (State or Foreign
	yland how		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	cation				10d. Inside City Limits
	Ba-f s	Director	MD Baltim	ore	Cocke	ysville				1 ☐ Yes 2 ☐ No
	or 26	Oire	10e, Street and Number			10f. Zip Code	· · · · · · · · · · · · · · · · · · ·	10g.	Citizen of What C	ountry?
	ath w	a	14 Chesham Ct				030		USA	
036	d within 72 hours after death with the Maryland jiene. Than "natural", or Itema 23a or 28a-f show the Mudical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	l l	Was Decedent of His f Yes, specify Cubar I ☐ Yes 2€ No	spanic Origin? (Spe n, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
က်	72	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	lent's Usual Occupa kind of work done di OO NOT use retired)	urina most of workin	16b	. Kind of Business	/Industry
212	filed within Hygiene. other than "lent. Inc. Mee.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Sales	Internet	Manager		Cars	
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	s 1 and 2 should I Health and Men Item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Ty Melissa Dean/w				nd Number or Rural Ct., Cod			
a a			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	ionioval ilotti State	20b. Place of Dispos cemetery, crem				. Location - City or	
altin	교원 변경 .		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Cons		Metro Cr	. Name and Address	9/6/0	-	tonsville,	
ă	Depa Impo any ii		Wichael L. Fla		> Le	mmon Full	neral Hom nia Rd.,	ne of Dula Timoniu	aney Val n, MD 2	ley, Inc. 1093
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	death. Do not ente	a the mode of dying	, Such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	, ,	+ 5ba	hand h	che		15 days
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	quires that n signed b uld be deta	þ	Part II. Other significant conditions cor	ntributing to death but no	ot resulting in the un	derlying cause give	n in Part I.	23e. Did tobacc		the cause of death?
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Z Z	cian: ertific ector,	Be	25. Was case referred to medical examiner?	1			26. Place of Death	Check only one		
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:	e Hospital or 24 hours afte a Funeral Dir letely filled in	Medicai	29a. Certifier (Check only one)	sician: To the best of m ter. On the basis of exa and manner stated.	amination and/or inv	occurred at the time estigation, in my opi	e, date and place, ar nion, death occurre	nd due to the cause d at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
:	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Mont	h, Day, Year)
	1) Simon Best	MD		T 1633			9/4/0	96
	0		30. Name and address of person who co	mpleted cause of death Tohas Hapkins	(Item 23a) (Type, F	Print) # 410 28	3 8511			
	Sta Registra		31. Date filed (Month, Day, Year)	Johns Hopkins 32 Registrar's	Signature	Will I				

06-06581 Andre Vincent Dudley Please Type or Print in Black Indelible Ink

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State	of Maryland / Department of Health and Mental Hygie	n

2006 28229

		1- For State Registrar		Cer	tificate of	Death		F	Reg No.	00	2022
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			6. Sex	7. Age (In yrs. Ia	set hirthdow)	If Under 1 Yea	r If Under 24	Hrs 8 Date of B	Birth (MM/DD/YYYY) 9	Rintholog	e (State or
Funeral		5. Social Security Number		Age (III yrs. la	ast bird iday)	Months Day	+		, 1 _E	oreign	
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should be filed with and Mental Hygiene 7 is marked other to natic event, the Men	ဥ	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailing	Address (Stree	et and Number	or Rural Route Nu	umber, City or Town, S	State, Zip	Code)
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygene tent 17 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once		Hridnea B	wrroll		1960	SPMOV	111	1800.	Bato Mi	12	1220
re, MD 21215-0036 s I and 2 should be filed within 72 hours affice fleatht and Mental Hygiene If item 27 is marked other than "natural".		20a. Method of Disposition			lace of Disposit		metery,	Date	20c. Location - Ci	ty or Town	State
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Balti permit Departm Imports injury o		21. Signature of Funeral Service	Licerisee	,	22. Na	me and Address	s of Facility		11 Ba	16.	rid 1.
E.E.C.8 00		K. Will	JAMa.	111	Ups	eiph'h.	Kilis	turnal	HLVE	* **4	2121
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8760, tificate be ng physic as the bur	M	IF FEMALE: 23b. Was decedent pregnant in t	he 23c. If yes,	outcome of preg		aldeath 3	Ectopic pre	anancy	23d. Date of de Month	livery Day	Year
68 certif nding se as		past 12 months?	I Live L	ant at time of de	oth -	ar douter	Ecrobic bre	agrianicy	IMONTH	⊔ay	Teal
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e Hos n 24 h e Fun letely		29a Certifier 1 Certifying P	hysician: To the bes	st of my knowled	ge, death occurr	ed at the time, d	ate and place,	and due to the ca	use(s) and manner as	started.	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Exa	aminer:On the basis and manner s	of examination a	nd/or investigation	on, in my opinior	n, death occur	red at the time, dat	te and place, and due	to the cau	se(s)
F. ≥ F. 0	Me	29b. Signature and title of certifi		, Latou		29c. Licens	se number		29d. Date signed	(Month, E	ay, Year)
			1	11		0.C.	M.E.		September 3	. 2006	
11		9	MI	11/				_	1	,	
1		30. Name and address of person	•								
2		Jack Titus MD. De	puty Chief Medi		_	n Street, Ba	timore, ME	21201			
S	tate	31. Date filed (Month, Day, Year,	32. F	gistrar's Signati	rge for	ill)					
Pagis		•	7 2006	100 a. P. a. 100 a.	ALTERIA	But we					i i

06-06406 Edward Dower, Jr.

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Certifica	ate of Death	Re	eg. No. 200	6 2023
Physicia Medical Exami		1. Decedent's Name (First, Middle, Last	DOWER	JR	2. Date of Dea Month August 26	Day Year	3. Time of Death 2327 hrs
		4a. Facility Name (if not institution, give Sinai Hospital	street and number)	4b. City, Town, or Loc Baltimore	cation of Death	4c County of Death	
Funeral Director		5. Social Security Number 2.1.2.54.7370 1 Usual Residence of Decedent	/ - 20		Hours Min. 8. Date of Bir	Foreign	hplace (State or nuntry) Www. (same
Maryland 28a-f show any 1 at once.	ior	10a. State 10b. County	10c. City, Town	impre			10d. Inside City Limits 1 Yes 2 No
th the Mary 23a or 28a- notified at	Director	10e. Street and Number	allco Rd	10f. Zip Code	15	0g. Citizen of What Coun	try?
ifter death wit I", or items 2 ner must be r	y Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year		nic Origin? (Specify Yes or No exican, Puerto Rican, etc.) pecify.	14. Race - Americ White, etc.	an Indian, Black,
15-0036 filed within 72 hours after death with the Maryland I Hygiene. 2d other than "natural", or items 23a or 28a-f sh 1, the Medical Examiner must be notified at once	Completed by	15. Decedent's Education (Specify on Elementary/Secondary (0-12)		Decedent's Usual Decupation during most of working life. DO		16b. Kind of Business/In	ndustry
c s g z s	a	17. Father's Name (First, Middle, Last)	Dower S	5r- 3	Mother's Name (First, Middle, N	Dower	
MD 21 d 2 should Ith and Me n 27 is ma numatic ev	<u>م</u>	19a. Informant's Name/Relationship (T	Itan	5701 WIA	Number of Rural Route Num	5 212	-15
imore, Pages 1 an nent of Hea aut: If iter or other tra		20a. Method of Disposition 1 Warral 2 Cremation 3 [4 Donation 5 Other Specify: 21. Signature of Funeral Service Limit	Removal from State cremate	of Disposition (Name of cemeter ory or other place) 22. Name and Address of	9/8/06	20c. Location - City or 5500 Ode DUNALK	Town, State AVID 21724
Balt permit Departi Import injury		23a. Part I. Enter the disease, or compi	plinen	Joseph L Rus	ss Funeral Hen	2 Balt wal	Approximate Interval
/Medical Examiner			ch line. Hypertensive cardiov Due to (or as a consequence of):	vascular disease		M	Between Onset and Death
	Ē		Due to (or as a consequence of):				
ted I Insit	Examiner	Clisease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
8760, rificate be executed ng physician and as the burial - transit	edical	X UNPENDED		perMe,g859,9/14/0	06 TT		
∞ ∓ ≈ 8		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of death 5		Ectopic pregnancy	23d. Date of delivery Month D	ay Y ear
, P.O. Box 61 rres that the death cert signed by the attendir be detached for use a	ē	Part II. Other significant conditions		g in the underlying cause giver		Dbacco use contribute to to	he cause of death?
Records The law requi	Completed				24a. Was a autop perfor 1 🗸 Yes	prior to comed? death?	opsy findings available ompletion of cause of S
ital Fician:	a		lospital:	- Ioth	Death (Check only one)	Parities o Clay	
n of Viding Physical After this funeral dir	on: To	1 ✓ Yes 2 No 27. Manner of Death 1 ✓ Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	Time of Injury 28c. Injury at		Residence 6 Other:	
Divisior Hospital or Attence 24 hours after death Funeral Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not to determine	28e. Place of Injury - At home, fa			Street and Number or Rur state)	al Route Number, City
To the Hospit Within 24 hour To the Funer.	Medical Ce	29a. Certifier (Check only 1 Certifying Physicia	an: To the best of my knowledge, dea: On the basis of examination and/or in and manner stated				
12/1	Me	29b. Signature and title of certifier	lews)	29c. License ni O.C.M.E		29d. Date signed (Mon August 27, 2006	th, Day, Year)
~		30. Name and address of person who cl Laron Locke MD. Assist	ant Medical Examiner 111	Penn Street, Baltimor	re, MD 21201		
St Regist	ate rar	31. Date filed (Month, Day, Year) SFP 0 7 20	32. Registrar's Signature	Grade .			

06-06586 Gina A Davis

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 28231

		1- For State Registrar	Certifica	ate of l	Death			Re	eg. No.	000	2023
Physicia	_	Decedent's Name (First, Middle,Last)	_					ate of Deal	th		ime of Death
		Gina Ann Davis					S	_{lonth} eptembe	Day Yea er 3, 2006	" (0015 hrs
and the second		4a. Facility Name (if not institution, give street and number)		4b	. City, Town, or L	ocation of		_	4c. County of	of Death	
		Baltimore Washington Medical Center			Glen Burnie				Anne Ar	undel	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	hday)	If Under 1 Year	If Under	24Hrs. 8.	Date of Bir	th(MM/DD/YYYY		ice (State or
Director		212-98-5653 1 M 2 X F 4	0	Yrs.	Months Days	Hours	Min.	10/25	/1965	Foreign Country) MD
	-	Usual Residence of Decedent	-	113.					7 2 7 0 3		
Ŕ	1		Oc. City, Town	or Locatio	n			-		100	d. Inside City Limits
_ %		MD Anne Arundel	C1 o	n Bur	nio					1	Yes 2 🔀 No
Aaryland 28a-f show any 1 at once.	힕	10e. Street and Number	010		10f. Zip Code			11	0g. Citizen of Wh	at Country?	
Mar r 28s	5				·					iat ooarii y	
ith the Maryland 23a or 28a-f sho		500 Aquahart Road			21061				U.S.A.		
h wit	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces?	ver in U.S.		Decedent of Hisp s, specify Cuban,				 14. Race White 		Indian, Black,
r dea or it mus	필	1 Yes 2 X	No							1 1 4	
s afte	à	3 Widowed 4 Divorced If Yes, Give Year or Dates:	D [40-	ha	Yes 2 X No					whit	
hour natu Exan	P G	15. Decedent's Education (Specify only highest grade compl Elementary/Secondary (0-12) College (1-4 or 5+		during mos	st of working life.	DO NOT L	ind of work (ise retired)	done	16b, Kind of Bu	siness/indus	stry
5-0036 led within 72 hours after death with the Maryland alygiene other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+		C +	esy Cle	n1-			Cmaga		
with with giene	E	17. Father's Name (First, Middle, Last)		Court			Name /Fire	st Middle 1	Groce 1		
filed Hyg		David I. Davis			[]				intrell	,	
21215-0036 uld be filed within 7 Mental Hygiene marked other than	ш	19a. Informant's Name/Relationship (Type, Print)	198	h Mailing	Address (Street				nber, City or Tow	n State Zin	Codel
D Shou shou and N artic	- I	Mr. David I. Davis / father							nie, MD		
, MD and 2 sho ealth and em 27 is	-	20a. Method of Disposition			on (Name of cem		Da Da		20c. Location -		
Of He	- 1	1 X Burial 2 Cremation 3 Removal from State	cremat	ory or othe	er place)	- 1				•	
im Pag ment fant: or of		4 Donation 5 Other Specify:	Ceda						Brook		
Baltimore, MD 21215-003 permit Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other traumatic event, the Med		21. Signature of Funeral Service Licensee					_		Funeral		
			101357						nie, MD		
Physician		23a. Part Enter the disease, or complications that caused th failure. List only one cause on each line.					rdiac or res	piratory arr	est, shock, or he		pproximate Interval letween Onset and
/Medical Examiner	1	Immediate Cause (Final disease a. Atherosclere		diovas	cular dise	ease					Death
		or condition resulting in death) Due to (or as a conseq	uence of):								
	اير	Sequentially list conditions, if any, leading to immediate Due to (or as a conseq	uence of):							-	
	Examiner	cause. Enter Underlying Cause	derice or _j .							- 7	
	xan	(Disease or injury that initiated events resulting in death) Last Due to (or as a conseq	uence of):			•					
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P.O. Box 687/ s that the death certifice gred by the attending pl	Physicia	1 Yes 2 No 9 ✓ Unknown 9 Unknown	me or death	5 Oth	er (Specify)						
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P.O.	<u>6</u>	Phencyclidine usage	odi noi resum	9 111 1110 411	denying dadde gi	Troit iii T di			_		√ 4 ✔ Unknown
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ord w req s bee	Set						'	24a. Was autop	sy p	rior to comp	y findings available of the state of
eco he law ate has	Ē							perfo		death?	2 No
tal Re(iian: The certificate		25. Was case referred to medical	-		26.Place	of Death (Check only	one)			
Vital Recysician: The l	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient	2 🗸 ER/O	utpatient	3 DOA	Other 4	Nursing Ho	ome 5	Residence 6	Other:	
Division of Vital Records, tal or Attending Physician: The law require rs after death all Director: After this certificate has been sited in by the funeral director, page 2 should be		27 Manner of Death 28a. Date of Injury	28b.	Time of In	jury 28c. Injur	y at Work?	28d	Describe	how injury occurr	ed	
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ivisior I or Attend after death Director:	iga	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Inju	ry - At home, fa	arm, street	, factory, office bu	uilding, etc	. 28f.			er or Rural F	Route Number, City
Divisior pital or Attend ours after death ceral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify)						or Town, S	State)		
		29a Certifier	knowledge, de	ath occurre	ed at the time, da	te and pla	ce, and due	to the caus	se(s) and manner	as started.	
To the Hos within 24 h	Medical	one) 2 Medical Examiner: On the basis of exami									use(s)
To wit	Mec	29b Signature and title of certifier		-	29c. License	number			29d. Date sign	ed (Month,	Day, Year)
		Allan Am W. N.	7		O.C.N	Л.E.			September	4, 2006	
		30. Name and address of person who completed cause of de	oth (Itom 22c)								
(4)		Melissa Brassell, MD Assistant Medical E		111 Pe	enn Street, B	altimore	, MD 212	201			
10/	tate				-						
	tate	SEP YOU 7 2006	Signature	100	rest 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 2, Year 7:33A M **EDWARDS Physician** VIRGINIA /Medical 4c. County of Death
BALTIMORE 4b. City, Town, or Location of Death ROSEDALE 4a. Facility Name (If not institution, give street and number) 1419 ROSEWICK AVENUE **Examiner** 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | 8. Months | Days | Hours | Min. 8 - 1.3 - 1.922 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** PA 1 ☐ M 2 💢 F Director 212-28-5382 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location s 23a or 28a-f sho ROSEDALE BALTIMORE MD 1 ☐ Yes 2X No Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21237 U.S.A. 1419 ROSEWICK AVENUE death v Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. or Itams 11. Marital Status The Madical Examiner 1. Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2**X**Xo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify WHITE þ 3 X Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 8 othar 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 12 should be f KEIPER CATHERINE (DEMKOVICH) ARCHIE and M 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ROSEDALE, MD 21237 Pages 1 and 2 nent of Health a ant: If item 27 Is 1419 ROSEWICK AVENUE DENNIS EDWARDS/SON othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXxuriai 2 Cremation 3 Removal from State 6 permit. Page Department of Important: If any injury or once. 9-7-2006 BROOKLYN, MD CEDAR HILL CEM. 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MD 21237 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner be executed and Due to (or as a consequence of). burialattending physician by Physician/Medical the The law requires that the death certificate as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown yd bei Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CONCESTIVE HEAT FAILURIE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 2 No 1 Yes 2 -No 1 Yes director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home **\$\times**Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No-Certification: To 28a. Date of Injury (Month, Day Year) funeral 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After or Attending 5 Pending 1 ENatural 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \(\text{Homicide} \) To the Hospital within 24 hours a To the Funeral C Lactifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 055306

State Registrar 31. Date filed (Month, Day, Year)

32. Registear's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PEN 15 H' DIE 9106 PH Comedit PD

EP 0 7 2006 Stepper Is Spell

Baltimore, Maryland 21215-0036

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Division of Vital Records, P.

Scrite 200 SALTO. MD 21257

Physician	1. Decedently Many After Action			Certificati	e oi Deal	n and Ment		No.	
/Medical	1. Decedent's Name (First, Middle Robert	Frank		mala			9 06		
Examiner	Franklin Squ		sital		Town, or Location		1	4c. County of Dea	m OFP
Funeral Director	5. Social Security Number 218 32 3599 Usual Residence of Decedent	6. Sex 7. A	ge (In yrs. last) 7 1		1 Year If Und	der 24 Hrs. 8. Da 's Min. (M	nte of Birth Jonth, Day, Yea	ar) 9. Bin	thplace (State or Foreignintry) aryland
thow	10a. State 10b. County		10c. City, To	own or Location		Jun			10d. Inside City Limit
be notified at Director	Md. Balt:	imore	Mi	iddle Ri					1 □ Yes 2 🙀 No
		ersity Dri	ve	10f. Zip	1220		10g. (Citizen of What Co U . S	
by Funeral	11. Marital Status 1 Never Married 2 Mari	If Yes Give	?	0 13. Was Deced		Origin? (Specify Y can, Puerto Rican, ify:	es or No- etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
Completed	(Specify only highe	t's Education st grade completed)		5a. Decedent's Usua (Give kind of wor life. DO NOT us	rk done durina π	nost of working	16b.	Kind of Business	Industry
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once. To Be Comple	17. Father's Name (First, Middle, Frank John	Emala			Ka	other's Name (First atherin	e Sc	chmincke	
er traum	19a. Informant's Name/Relations Debra Corvi		10	9b. Mailing Address 816 Unive					
0 0	20a. Method of Disposition 1 Burial 2 □ Cremation			of Disposition (Nantery, crematory or o		Date		Location - City or	
DCB.	4 □ Donation 5 □ Other (S 21. Signure of Funeral Service		Grant	tsville Co Bruzdz		9/11/200 Uneral Ho			, Maryland
a	23a. Part1. Enter the disease, or	complications that cause	d the death. D					x, Maryl	and 21221 Approximate
an al	Shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	- Blas	1 1.	sis					Interval Between Onset and Death
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Acute	A consequen	reloid	Leuk	emia			
licai Exa	that initiated events resulting in death) Last	c. Due to (or as	a consequenc	e of):					
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pletely filled in by the funeral director, page 2 should be detached for use as the buu edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. 23c. If yes, outcome 1	of pregnancy 2 Fetal dea t time of death but not resulting Disc Can ent 2 ER/C Ify y Year) 28b ury - At home, c. (Specify) of my knowledge f examination a ated.	Dutpatient 3 DO Time of Injury M farm, street, factory ge, death occurred a and/or investigation,	26. Pla A Other: 4 Bc. Injury at Work? 1 Yes 2 at the time, date in my opinion, d License numbe	24 10 10 10 10 10 10 10 10 10 1	1 Yes 1a. Was an autopsy performed? Yes 2 No. Revenue of the case of the cause of	Month Duse contribute to 2 No 3 pr. 24b. Were au prior to c death? 1 Yes 6 Other (Speciary occurred land Number or Rule) (s) and manner as no place, and due plate signed (Month)	Day Year the cause of death? bably 4 □Unknown topsy findings available completion of cause of 2 □ No ral Route Number, stated. to the cause(s) i, Day, Year)

Registrar

SEP 07

2006

			1 - For State Registrar	State of N	//arylan	d / Depa	artmen rtificat	t of H e of L	ealth a Death	and M	ental Hy	ygiene Reg. No		5	28235
k	Physici	»	Decedent's Name (First, Middle,	Last)							2. Date of D				3. Time of Death
	/Medi	cal			RELL							nber	1, 200	6	5:15 p ^M
18	Examir	ner	4a. Facility Name (If not institution,						Location o	of Death		40	County of De		
	Funeral		Genesis Elderca 5. Social Security Number	6. Sex 7. /	Age (In yrs.	ies last birthday)	If Under		If Under 2		8. Date of Bi	irth	Prince 9.8	irthpla	ce (State or Foreign
d./3	Director		412-46-8206	1□M 2∏ F	76	Yrs.	Months	Days	Hours	Min.	Month, D Dec. 1		00	Country nne:	ssee
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					, ,		100	t. Inside City Limits
	Mary -feho	tor	Maryland Prince		н	ya t tsv	411a								1 X Yes 2 No
	th the	Director	10e. Street and Number	e George's		Jacesv	10f. Zip	Code				10g. Ci	itizen of What	Country	y?
	ath wi		3701 Kennedy F	lace			2	0782				Ţ	J.S.A.		
	er de:	Funeral	11. Marital Status	12. Was Deceder	5?		Was Deced If Yes, spec	dent of His city Cubar	spanic Orig n, Mexican	gin? (Spe i, Puerto F	cify Yes or N Rican, etc.)	0-	14. Race - Ar Black, Wi		
936	urs aft	by F	1 ☐ Never Married 2X Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 □ Yes 2 5 If Yes, Give Year or Dates			1 🗆 Yes	2 ∏ No	Specify:				Specify: W	hit	e
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or Iteme 23a or 28a-1 ehow ha Madleal Exeminar mast te notified at	sted	15. Decedent's (Specify only highest	Education			dent's Usua kind of wo			t of working	20	16b. k	(ind of Busines	ss/indu	stry
2	rithin ne. nen	Completed	Elementary/Secondary (0-12)	Colfege (1-4o	r 5+)	life.	DO NOT us	se retired)		Or WOTKII	ig .		nting		
22	Hygier ther ti nt, to		12 17. Father's Name (First, Middle, L	ast)		Reco	rds M	_		r's Namo	(First, Middle		ernatio	ona?	l
au	ld be i	To Be	Heiskell Price									o, maider	Julianie)		
ary	shoul ind Mari	F	19a. Informant's Name/Relationshi			19b. Maili	ng Address	(Street a		lah r or Rura		ber, City	or Town, State	, Zip C	ode)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "neturel", or Iteme 23a or 28a-f show way injury or other traumatic event, the Macical Examination at a notified at ance.		Carroll Ferrel	1 - Spouse		3701	Kenn	edy 1	Place	. Hy	attsvi	11e.	Maryl.	and_	20782
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ⊠Removal from Stat	C	lace of Dispo emetery, crei	osition (Nan matory or o	ne of ther place		D	ate	20c. L	ocation - City	or Town	n, State
Ē	t. Pag tment tant: ijury o		4 Donation 5 Other (Sp.	ecity)	Me	wkins morial	Gard	ĕn			9/06	Rog	ersvil.	le,	Tennessee
Ba	Depariment Department of the popular in popu		21. Signature of Funeral Service 1	gensey		/.	2. Name an 720. 10.	d Addres	s of Facility	y Gas	sch's	Fune	ral Hom	ne,	P.A.
			23a. Part1. Enter the disease, or o	omplications that caus	ed the death	n. Do not ent	ter the mod	e of dying	, such as	cardiac or	respiratory a	CSV1. arrest,	11e, MI	A	pproximate
	Physician		shock, or heart failure. List o Immediate Cause (Finat disease or condition	ny one cause on each Seps											nterval Between Inset and Death
7	/Medical		resulting in death)	a	is a consequ	uence of):						-			
**	Examiner	_	Sequentially list conditions,	b											
/	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a consequ	uence of):									
	execu n and al-tra	Exar	that initiated events resulting in death) Last	c Due to (or a	is a consequ	uence of):								-	
8760,	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dlcall	•	d.											
9	ng ph	0	IF FEMALE:											1	
P.O. Box	eath certific attending p	by Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 Fetaf	death 3	Ectopic pr						23d. Date of d	lelivery Da	
о О	he de	yslc	1 □ Yes 2 🖾 No 9 □ Unknown	4□Pregnant 9□Unknown	at time of de	eath 5	Other (sp	ecify)					WOTH		ay roat
	res that the de signed by the a be detached to	y Ph	Part fl. Other significant condition	s contributing to death	but not resu	ılting in the u	nderlying ca	ause give	n in Part f.		23e. Did	tobacco	use contribute	to the	cause of death?
Division of Vital Records,	w requires been sign should be		Endocarditis, N	on-Hodgkin	s Lymp	ohoma	with	CNS	Invol	veme	nt, 1□	Yes 2	□No 3□	Probab	fy 4 ⊠Unknown
၀၁	e law re has bee je 2 sho	Completed	Pneumonia, Deep	Venous Th	rombos	sis					24a. Was		24b. Were	autops	y findings available
Ě	The ate h	E O									auto perfe	omed?	death	?	itetion of cause of
V ita	ysician: The is certificate hi director, page	Be	25. Was case referred to medical examiner?	Hospitali							(Check only				
0	Phys r this ral dir	2	1 ☐ Yes 2 ☒ No 27. Manner of Death			ER/Outpatier 28b. Time of		A Cthe	r: 4⊠ Nur		ne 5 Res		6 Other (Sp	ecify)	
O	th. : After s funer	tlon	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of In (Month, D	ay Year)	Injury	M	8c. Injury Work 1 □ Y	? es 2□N		ou. Describe	now inju	ry occurred		
N N	Atter	Certification	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place of I	njury - At ho atc. (Specify	me, farm, str	eet, factory	, office		2			nd Number or i	Ru <i>ral F</i>	Route Number,
ā	ital or rs afte rat Die led in	Cer	- Individue	Building, t	этс. (Зреспу	, 					City or To	wn, state	3/		
	To the Hospital or Attending Physician: whin 24 hours after death. To the Funatal Director: After this certified completely filled in by the funeral director,	ical	(Check only 2 Medical E:	Physician: To the best	t of my know of examinat	wledge, death ion and/or in	n occurred a	at the time	e, date and inion, deat	d place, a h occurre	nd due to the	cause(s) and manner a	as state	ed. e cause(s)
	o the ithin 2 o the	Medical	29b. Signature and Me of pertities	and manner	stated.			. License					te signed (Mo		
	⊬ ક⊨ં ઇ			Shon	M.D		250		182	13.			7/05/		•
•	1)		30. Name and address of person w	no completed cause of	death (Item	23a) (Type.	Print) N				M. D		1 -1		-
	10		4410 74th Aven							ا و شدت	י עוייי				
	Sta		31. Date filed (Month, Day, Year)		trar's Signat		-								
70	Registr	dl'			2	A 1	DI a								

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 206 28236 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 2, 2006 **Physician** George Richard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fulton Howard 12012 Scaggsville Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day, 1926) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**∑** M 2□ F 216-16-9551 80 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental Hygiene. importent: If item 27 is marked other than "natural; or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits s 23a or 28a-f show 1 Yes 2 No Director Maryland Howard Fulton. 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 12012 Scaggsville Road 20759 United States of Americia Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 DYes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Tool & Dye Maker Armco Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Margaret Schuler Edward Fewster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12012 Scaggsville Rd., Fulton, MD 20759 Dorothy Sanborn (Daughter) 20a. Method of Disposition
1 ☐ Burial 24 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metro Crematory September 5, 2006 Baltimore, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 21. Signature of Funeral Service Licensee MC0333 8728 Liberty Rd. Randallstown, MD 21133-4784 Kellner 23a. 16.1. Enter the discale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Coronary disease or condition resulting in death) Years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) physicien and the burial-transit Cause (Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ mess. Bowel 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 sidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 은 Certification: 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Anatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel (Secritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier ical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) Sel 5 2006 10 SAINI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 211 MD 31. Date filed (Month, Day, Year) SEP 0 7 2006 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

			1- State of Maryland / Department of Health and Certificate of Death		en 2 006	28237
			Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		William Floyd		31 2006	2:24 А.м
	Examin	er	4a. Facility Name (If not institution, give street and number) Baltimore Washington Medical Cen. 4b. City, Town, or Location of De	eath	4c. County of Deat	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	lin (Month, Day,)	Year) 9. Birth	hplace (State or Foreign untry)
	Director		214 18 1869 1\(\mathbb{M}\) 2 \(\mathbb{F}\) 83 Yrs. World's Bays Holls Mathbb{M} Washington 1 \(\mathbb{M}\) 1 \(\mathbb{M}\) 2 \(\mathbb{F}\) 83 Yrs. World's Bays Holls Mathbb{M} 1 \(\mathbb{M}\) 1 \(\mathbb{M}\) 1 \(\mathbb{M}\) 2 \(\mathbb{F}\) 83 Yrs. World's Bays Holls Mathbb{M} 1 \(\mathbb{M}\) 1 \(\mathbb{M}\) 2 \(\mathbb{F}\) 83 Yrs. World's Bays Holls Mathbb{M} 1 \(\mathbb{M}\) 1 \(\mat	Feb. 23,	1923 Mai	ryland
	land ow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Man, a-1 sh	tor	Maryland Anne Arundel Baltimore			1 ☐ Yes 2X No
	th the	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	untry?
	ath w		5711 Phillips Street 21225		U.S.	in a ladina
	er de	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ▼ Married 12. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	' (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, White	
99	hours after death with the Maryland tural', or Itams 23a or 28a-1 show al Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: WW II 1 ☐ Yes 2 ☑ No Specify:		Specify: Wh	ite
2-C	72 ho natur iical	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of v	working 1	6b. Kind of Business/	Industry
121	filed within 72 Hygiene. other than "na' ant, the Medic	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	T.	W.R. Grace	
N 0	filed v Hygie ther t		Oth	Name (First, Middle, M.		
Maryland 21215-0036		To Be		ry Andersor	n	
ary	permit. Pages 1 and 2 should be Departurent of Health and Menta Important: If item 27 is marked any injury or other traumatic av <u>once</u> .	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or			
∑ ″	and and lealth m 27 har tra		Matilda Floyd / wife 5711 Phillips Street		re, Maryla:	
õ	iges 1 nt of H : If ite or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetary, crematory or other place)		Baltimore,	
Baltimore,	artmer artmer ortant injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee A 22. Name and Address of Facility	,		
Ba	Depi Impo		Jerome Brancisca 1 4001 Ritchie High			•
	2.		23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Co RONARY ARTS 1774	DISEAS	٤	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. HypEIZTEN 810 N Due to (or as a consequence of):			
	outed id ansit	Examiner	Cause (Disease or injury that initiated events			
Ö,	e exec	Exc	resulting in death) Last Due to (or as a consequence of):			
8760	icate be executed physician and s the burial-transit	dicai	d			
9 X	certifii nding p	/Me	IFFEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of del	ivery
Box	that the death certifined by the attending I	Physician/Me	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
P.0	at the by the stache	hys	9 Unknown	T		the second death 2
	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to s 2□No 3□Pr	2
oro	requi	eted	DIZINZ OCA DDZI CHIZONOMA WINE	24a. Was an		itopsy findings available
Records,	sician: The taw s certificate has b lirector, page 2 s	Completed	PIEGASTASZA TO LONG, PELVIS	autopsy perform	prior to	completion of cause of
Vita	an: T tificate tor, pa	Be Co	PULMONARY F113120545 25. Was case referred to medical 26. Place of 0	1 Yes 2 Death (Check only one		2
	nysicia nis cer direct	To B	examiner? 1 Yes 2 No	ig Home 5 ☐ Resider	nce 6 Other (Spe	cify)
Division of	ding Phys		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?	28d. Describe how	w injury occurred	
isio	death ctor: /	icat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stre	eet and Number or Ru	ural Route Number,
<u>≤</u>	or Attendation after deation Director:	Certification:	4 Homicide determined determined building, etc. (Specify)	City or Town,		
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page		29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plant (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death o	lace, and due to the car	use(s) and manner as	s stated.
	the H nin 24 the Fi	Medical	one) and manner stated.		d. Date signed (Mont	
	To To	~	29b. Signature and file of certifier 29c. License number 29c. Lice		Lac signed (World	T 31 00
•			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	(/ /	TUG U>	10106
	107		RICHARD E FISHER 4710 PENNING	TON AU	E BALY	-IHORE MI
	Sta		31. Date filed (Month, Day, Year) 32. Abgistrar's Signature			
	Registi	1	CED 0 7 2006 December 15 Comme			

		1	For Amend Item Registrar	State of Maryland 2,29d per dr	d / Departmer • • G859 . 09 / • • • Gertill Cal	it of Health and N 07/06dhb e of Death	Mental Hygie	ene . No. 2006	28238
	Physicia	_	1. Decedent's Name (First, Middle, Last)	Ilie	Gree	<u>-</u> n	2. Date of Death	09/04/2006 Day Year	3. Time of Death 729p M
	/Medic Examin	er	Baltimore	freet and number) A NECLICA (7. Age (In yrs. Is	enter B	Town, or Location of Death	2	4c. County of Death	ace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 12 12 13 14 15 15 15 15 15 15 15 15 15 15 15 15 15	M 2□F 7	Yrs. Months		8. Date of Birth (Month, Day, Y	(931) 1931	KOK
Maryland	a-f show ified at	tor	10a. State 10b. County	10c. City	Town or Location	nore			Od. Inside City Limits 1 ☐ Tes 2 ☐ No
th with the	23a or 28. Jat be not	Funeral Director	10e. Street and Number	stliew H	Ell. o	21206		g. Citizen of What Count	
filed within 72 hours after death with the Maryland	al', or itsme Examiner m	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1	S. 13. Was Dece If Yes, spe 1 \sum Yes	dent of Hispanic Origin? (Socity Cuban, Mexican, Puert 211 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, s	
ad within 72 hours af	ne. than "natur se Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)			ial Occupation ork done during most of work use retired)	king	6b. Kind of Business/Ind	le le le
9	Mental Hygien arked other th atic svent, the	To Be Co	17. Father's Name (First, Middle, Last) Tohn Willie	o breeze			ne (First, Middle, Mi		Company
~ 6	Health and lem 27 is m other traum		19a. Informant's Name/Relationship (Ty) 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ R	emoval from State	lace of Disposition (Na emetery, crematory or	other place)	liew /	City or Town, State, Zip	D. MD. 2134
Danes 1	Department of important: if it is any injury or o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License		22. Name a	and Address of Facility	OWEIT F	Coungo:11 Euserai /	tone
	hysician /Medical xaminer		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	CANCER		c or respiratory arres	st,	Approximate Interval Between Onset and Death
		dicai Examiner	Sequentially list conditions, days leading 1 mm a final cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t					
Critical And Company of the death configurate he executed	by the attending phatached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of do	death 3 Ectopic			23d. Date of delive Month	ory Day Year
	n signed by		Part II. Other significant conditions con	-		cause given in Part I.	23e. Did toba	acco use contribute to the	
Draight: The four confeet	cate has been si page 2 should	Completed by					24a. Was an autopsy perform 1 \(\text{Yes} \) 2	prior to cor	psy findings available inpletion of cause of
	certificate	Be	25. Was case referred to medical examiner?	In a what is			ath (Check only one)	100/
	th. th. After this c funeral dire	ition: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 [28c. Injury at Work? 1 Yes 2 No	dome 5 Resider 28d. Describe how	nce 6 Other (Specifi w injury occurred	у)
TOISIAID.	To the nospital of Attending Printing of Whiting At hours after death. To the Funeral Director: After to completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office	28f. Location (Str. City or Town,	eet and Number or Rura State)	I Route Number,
	e nospi 24 hour s Funeri letely fille	Medical (29a. Certifier (Check only one) 1 ★ Certifying Phy 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date and place on, in my opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner as si te and place, and due to	tated. the cause(s)
	within To th compl	Me	29b. Signature and title of certifier	11050 1	9c. License number	S	d. Date signed (Month, eptember 6,	^{Day} 2006	
			30. Name and address of person who ca	ompleted cause of death (Iter	n 23a) (Type, Print)		A . 71 -		2006
7	St	tate	GRAHAM SNYPE 31. Date filed (Month, Day, Year)	32. Registrar's Signa	AREENE ature	STREET BI	4-TIMOIZE	MP 212	201
	Regist		31. Date filed (Month, Day, Year) SEP 0 7 2006	Jacob Jac	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygien 2006

28239

			1 - For State Registrar	State of Mary		rtificate of			g. No.	20203	
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death	
	/Medic	al	Rita Ruth 4a. Facility Name (If not institution, give s		nboth	4h Cihi Tourn a	r Location of Death	Septemb	er 6, 2006		
	Examin	er	730 Milldam Road	are and number,		Towso			Baltimore		
	Funeral Director		5. Social Security Number 6. Sex 217-20-2820	M 2 F 7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept. 1	O Rieth	place (State or Foreign ntry) yland	
	yiand yow		10a. State 10b. County	100	. City, Town or Lo	ocation				10d. Inside City Limits	
	e Mar	ctor	Maryland Baltimor	^e	Towson					1 Yes 2 No	
	with th	Dire	10e. Street and Number			10f. Zip Code	006	109	g. Citizen of What Cou	ntry?	
	ne 23s	erai	730 Milldam Road	12. Was Decedent Ever	in U.S. 13.		286 Iispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Amen	can Indian	
Baltimore, Maryland 21215-0036	within 72 hours after death with the Maryland ene. then "natural", or iteme 23e or 28e-f ehow he Madigal Examinar rount by notified at	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates:	l l	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, White,		
15-(n 72 h	lete	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece	dent's Usual Occup	nation during most of work d)	ing 16	6b. Kind of Business/Ir	ndustry	
212	l withir iene. r then	ошр	Elementary/Secondary (0-12)	College (1-4or 5+)		counting)		Hutzler's		
멀	al Hyg 1 other	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma			
yla	iouid b Ment narked	To	3	ertner			Estelle		nknown		
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Je,			20a. Method of Disposition	20	the state of the s	sition (Name of natory or other place	a Constitution		Oc. Location - City or T	own, State	
<u>E</u>			1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	}	lilltop S		orp. 911/	06 To	owson,Maryl	and	
Balt	permit. Depertimport import any inj		21. Signature of Funeral Service Liverise	⇔ William G.		2. Name and Addre	Rd., Tow	k Towson son, MD	Funeral Ho 21204	ome, Inc.	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on tmmediate Cause (Final	e cause on each line.		Y .		or respiratory arres	it,	Approximate Interval Between Ohset/and Death	
	Physician /Medical		disease or condition resulting in death)	Due to (or as a con		DU	amig			4 BMO	
	Examiner		Comparielly list out Minus								
_	S P E	nlner	E squentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):						
Ć.	execu	Examiner	that initiated events cresulting in death) Last	Due to (or as a con							
68760,	death certificate be executed e attending physicien end of for use as the buriat-transit	Physician/Medical									
	ding pl	/Med	IF FEMALE:	23c. If yes, outcome of pregnancy							
Вох	thet the death cer ed by the attendir detached for use	clan	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live birth 2 F 4 Pregnant at time	etal death 3	Ectopic pregnancy Other (specify)	<u>'</u>		23d. Date of deliving Month	ery Day Year	
P.O.	by the	hys	9 ☐ Unknown	9 Unknown							
Records, F	The law requires thet the site has been signed by the page 2 should be detached.	by	Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to t	he cause of death?	
ecc	hes be	Completed						24a. Was an autopsy	24b. Were auto	ppsy findings available impletion of cause of	
e E	The licete I							performe	death? No 1 ☐ Yes	2 40	
=	Physician: rthis certifice ral director, p	To Be	25. Was case referred to medical examiner? 1 Yes	ospital:	2 🗌 ER/Outpatien	t 3 DOA Oth	or	Check only one	ce 6 ∏Other (Specia	W1	
0	ng Phy ter thi neral		27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Yea.	28b. Time of		y at	28d. Describe how		y)	
Sio	Attending ir death. ector: After by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be			M 1	Yes 2 □ No				
Division of Vital	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificete he completely filled in by the funeral director, page	Certification:	4 Homicide determined	28e. Ptace of Injury - A building, etc. (Sp	At home, farm, streetify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,	
	Hospital 24 hours 2 Funeral I etely filled	Medical	29a. Certifier Cartifying Phys (Check only one)	ician: To the best of my er: On the basis of exan and manner stated.	knowledge, death nination and/or inv	occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as s and place, and due to	tated. the cause(s)	
	To the Ho within 24 I To the Fu completely	Me	29b. Signature and tale of certifier	01/	1	29c. Licenso		29d	. Date signed (Month,	Day, Year)	
) Tolor	STHUC	sul	D36	514		116/06		
	4		30. Name and address of person who co	pleted cause of death (Item pe,	Print) Print)	DO Cin	-Z00	716/06 Towson	Mr	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	6 w	-C, JC111	6 2 21	1000311		
	Registr		CED 6 7 20	ne l Ko	20 4	200 B. 1					

		For State Registrar	State of Marylan	d / Depa <i>Cer</i>	artment of H	lealth and N Death		en 2006	28240		
E		Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death		
Physic /Medi		Ruth	Albie	Guolo			Septembe	r 1, 2006	4:00 A M		
Exami		4a. Facility Name (If not institution, give str			4b. City, Town, or	Location of Death		4c. County of Death			
			l Bridge Road			owson			imore		
Funeral Director		5. Social Security Number 6. Sex 287-22-0466	7. Age (In yrs. 75		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth Con	nplace (State or Foreign Intry) hio		
portition of the profile and a should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme 23e or 28e-1 ehow eny injury or other traumatic event, the Medical Examinar must be notified at encelled at once.	To Be Completed by Funeral Director	10e. Street and Number 908 Cromwel	1 Yes, Give Year or Dates: ation completed) College (1-4or 5+) 16a. Deced (Give Fife. Deced) Kolacek		Was Decedent of H 1 Yes, specify Cuba 1 □ Yes 2 No dent's Usual Occup kind of work done DO NOT use retired Homemake	during most of work d) T 18. Mother's Nam	ecify Yes or No-Pican, etc.) 16 16 16 17 18 18 18 18 18 18 18 18 18	b. Kind of Business/I	ican Indian, o, etc. White Industry me		
politing of your permit. Pages 1 and 2 st Department of Health and Important: If item 27 is represently injury or other trauspace.		Mr. Ely C. Guolo/Hu 20a. Method of Disposition 1 Burial 2 ØCremation 3 Be 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	sband moval from State Hi	908 (Place of Disponentery, crem	Cromwell sition (Name of place of place)	Bridge Ro co) corp. 9/8/ ss of Facility RL	f. Towsor Date 20	n, Marylan oc. Location - City or owson, Mar on Funeral	rown, State		
by Oct. The purial-transit the burial-transit the	dical Examiner	23a. Part 1. Enter the disease, or confolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Unorthing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
death certific	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Other significent conditions cont	c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	/	23a Did toha	23d. Date of deli	Day Year				
has 1962	Completed by						1 ☐ Yes : 24a. Was an autopsy performe	2 No 3 Pro	obably 4 Punknown topsy findings available completion of cause of		
	e Co	25. Was case referred to medical				OR Diagram of Day	1 ☐ Yes 2√ th (Check only one)	∠No 1 □ Yes	2□ No		
ng Phys Mter this Ineral di	To B	eyaminer?	spital: 1 ☐ Inpatient 2 ☐ 28a. Date of fnjury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injur Wor	er: 4 ☐ Nursing H		ce 6 Other (Spec	HOSPICE		
UNISION To the Hospital or Attending within 24 hours after death. To the Funerel Director: Afte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special		reet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	iral Route Number,		
the Hospi hin 24 hou the Funer npletely fill	Medical	(Check only 2 Medical Examination)	cian: To the best of my kno er: On the basis of examina and manner stated.			pinion, death occur	rred at the time, dat		to the cause(s)		
C Tiking		29b. Signature and title of certifier	h_MP.	000		P41476		09:05.			
4		KKI Jecom do	m.p. 6565 H	CHARLES	St Swite	416 BALTI	imore mo	21204			
Si Regis	tate trar	31. Date filed (Month, Pay, Year)	32. Régistrar's Signa	A A	and !						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005

		•	For State Registrar		State of Ma		rtificate of			a. No.	28241			
	Physici	an	1. Decedent's Name	(First, Middle, Las	st)				Date of Death Month	Day Year				
	/Medic	al	ROSE PASK IN 4a. Facility Name (If r		o stroot and oumber)		4h City Town o	r Location of Death	SEPTEMBER	4, 2006 4c. County of De	5:33 P ^M			
	Examin	er	3165 ZACK'S		e street and number)		HUNT I NGT			CALVERT	atti			
	Funeral		5. Social Security Nur	mber 6. S		e (In yrs. last birthday,		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		irthplace (State or Foreign Country)			
	Director		102.03.2549		□ M 2□ F XX	93 Yrs.	Worting Days	Tiours Ivian,	JUNE 15,	1913	NY			
	land ow		Usual Residence of E 10a. State	10b. County		10c. City, Town or L	ocation		<u> </u>		10d. Inside City Limits			
	Mary a-f sh	tor	MD	CALVEI	RT	HUNTINGTO	WN				1 ☐ Yes 2 ☐ No XX			
	or 284	Director	10e. Street and Numb				10f. Zip Code		10	g. Citizen of What (
	s 23a		3165 ZACK'S	PALCE			20639			USA				
	ter de	Funerai	11. Marital Status 1 □ Never Married	d 2□ Married	12. Was Decedent Amed Forces? 1 ☐ Yes 2 🛣	Everin U.S. 13.	If Yes, specify Cubi	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	14. Race - An Black, Wh				
999	ours af	þ	XX Widowed 4	_	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: W	HITE			
5-0	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Items 23a or 28a-f show ent, the Medical Examinar must be notified at	Completed	(Specify	5. Decedent's Ed only highest gra	ducation ade completed)	(Give	dent's Usual Occup	during most of works	ng 1	6b. Kind of Busines	s/Industry			
2	within ene. than	mp	Elementary/Second	dary (0-12)	College (1-4or 5	5+)	DO NOT use retired E WORKER	a)		DAVING				
2	filed Hygid other ent, I	a)	17. Father's Name (F	irst, Middle, Last,)	OFFIC	L WUNKEN	18. Mother's Name	(First, Middle, M	BAKING laiden Sumame)				
lan	uld be Mental irked o	To B	PAUL PASKII	١				FANNY SHA	PIRO					
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. It a Modical Examiner must be nutified at once.		19a. Informant's Nan	ne/Relationship (Type, Print)	19b. Maili	ng Address (Street	and Number or Rura	al Route Number,	ber, City or Town, State, Zip Code)				
			20a. Method of Dispo		DAUGI	TER 3165 20b. Place of Disp	ZACK'S PLAC	E HUNTINGTO		39 0c. Location - City o	r Town State			
nor				Cremation 3X	Removal from State	cemetery cre BIBLE	GARDENS							
Baltimore,	permit. F Departmi Importar any injur		21. Signa 1 1 un			2	SREAL 2. Name and Addre NK FUNERAL	ss of Facility	5, 2006	MOODBRIDGE,	NJ			
<u> </u>	89 = 9		K GREC	ORY FINK	- 4	M01148 42	6 CRAIN HWY	SW GLEN BUI						
					plications that caused one cause on each li	the death. Do not en	ter the mode of dyir	ng, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death			
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	Examiner				met	a consequence of y	Breo	st cor	rei					
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30X	ath cel ttendir or use	an/N	IF FEMALE: 23b. Was decedent p in the past 12 m			2 Fetal death 3	□Ectopic pregnancy	/			•			
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rds	w requires that s been signed k should be deta	ed b		~ ~ ~	one				1 🗆 Yes	XX 2 □ No 3 □ F	Probably 4 Unknown			
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<u>~</u>	: The cate h								perform	ed? death? □No 1□Ye				
<u>=====================================</u>	sician: The law certificate has b irector, page 2 sl	o Be	25. Was case referre examiner? 1 Yes 2XXN		Hospital:	ent 2 ER/Outpatie	oth Oth	26. Place of Death) nce 6 □Other (Sp				
1 0	Attending Physician: r death. ector: After this certifica by the funeral director, i	-	27. Manner of Death		28a. Date of Inju	ry 28b. Time o		y at	28d. Describe hov		өспу)			
Sion	ending I eath. or: After he funer	atio	XX Natural 2 Accident	5 ☐ Pending investigation 6 ☐ Could not b	n	y / Gui / Injury		Yes 2 □ No						
Division of Vital Records,	or Attence after death Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined		ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,			
_	spital		29a. Certifier	XXCertifying Ph	nysician: To the best	of my knowledge, dèa	h occurred at the tir	me, date and place,	and due to the car	use(s) and manner a	as stated.			
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	one)		miner: On the basis o and manner st	f examination and/or in ated.								
	To the vithin compl	Σ	29b. Signature and ti		N OLLK	MD	29c. Licens	560638		d. Date signed (Mor $9/5/06$				
1			30. Name and addres		completed cause of c	leath (Item 23a) (Type				1-106	D			
5			MENDON			RD. PRINCE F		D 20678						
	Sta Registi		31. Date filed (Month	SEP 0 7	32. Registr	ar's Signature	Carte							
	negisti	या		SETUI	LOUD ME CAR	100 10								

DHMH 17 Rev 1/2001

amend 24-29, per Dr. Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 28242 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7: 05 PM 2006 Baby Girl Goldring /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Charles La Plata, MEDICAL Center civista If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 X F A Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or itema 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No White Plains Director MD Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9914 Rhodes Way Lot A 20695 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Specify: black 1 ☐ Yes 21 No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic one. Elementary/Secondary (0-12) College (1-4or 5+) none none 18. Mother's Name (First, Middle, Maiden Surname) none 17. Father's Name (First, Middle, Last) Francis C. Knott Jr Sara Goldring 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Civista Medical Center 700 E. Charles Street Laplata, MD 20695 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☑Other (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signatur Funeral Servit e Licensee Ronald S. Wa *P*irector Baltimore, MD 21201 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prematurit **Physician** /Medical Due to (or as a consequence of) Examiner Separative of the second secon Due to (or as a consequence of) physician and the burial-transit Due to (or as a consequence of): the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of deliver 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician/Medical Completed by page 2 should tor: After this certifi-the funeral director Be

Certification:

P.O. Box 68760

Division of Vital Records,

death.

within 24 hours after or To the Funeral Direc completely filled in by

25. Was case referred to medical examiner?

29b. Signature and Mye of certifier

1 Yes 2 XNo

4 | Homicide

29a. Certifier

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 26. Place of Death (Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Npatient 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

2 ☐ ER/Outpatient 3 ☐ DOA

Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in an entire of each place. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospita1

29d. Date signed (Month, Day, Year)

of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

James 31. Date filed (Month, Day, Year) SEP 0 7 2006

Vite K MD 32. Registrar's Signature Civista

	1- For Amend item 28 take of Mary 2000, December 1- State Registrar Certificate of Death	ntal Hygiene Reg. No		
Physician	T. 1. 3.	Date of Death Month Day	30,2006 2:20 PM	
/Medical Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 37 Greenwood Avenue Overlea	4c.	County of Death	
Funeral Director		Date of Birth (Month, Day, Year)		
death with the Maryland me 23a or 28e-f show friest by radified at neral Director	10a. State 10b. County 10c. City, Town or Location Florida Citrus Beverly Hills	3	10d. Inside City Limits 1 ☐ Yes 2 🖾 No	
with the Mar 3a or 28e-f e	10e. Street and Number 10f. Zip Code 15 East Golden Street 34465		izen of What Country?	
9 2 3 J	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: 1 Yes 2 No Specify:	·	14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		ind of Business/Industry	
d 2 should be filed within and 2 should be filed within 17 is and Mental Hygiens 77 is marked other than 1 traumatic event, the Miss To Be Complé	12 Supervisor 17. Father's Name (First, Middle, Last) Palmer Giubilo Irene		Sumame)	
ges 1 and 2 should be filed within to f Health and Mental Hygiene. If them 27 is marked other than or other traumatic event, the M	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Form. Christopher Hatcher, Son 23 Hyacinth Road Pa	Route Number, City o		
t. Pa rtmen rtant:	1 □ Burial 2 ▼Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) Cemetery, crematory or other place) Bayview Crematory 9/1/		Ltimore, Maryland	
permi Depa Impo eny ir	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marz 1 6009 Harford Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respectively.		neral Chapel, P. Anore, Maryland 212	
by Science of Science	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):		3 months	
death certific e attending p ed for use as t	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco t	use contribute to the cause of death?	
sicien: The law requir centificate has been si irector, page 2 should o Be Completed		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No	
ng Phy fler this ineral d	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No	3 2 Aestidence d. Describe how inju	nd Number or Rural Route Number,	
he Hospital or in 24 hours afti he Funeral Dii pletely filled in edical Cer	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	d due to the cause(s) and manner as stated.	
To the Hospital or Attendia within 24 hours atter death. To the Funeral Director: A completely filled in by the funeral Completely filled in Completely filled in the funeral Certification	one) and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Da	te signed (Month, Day, Year)	
10	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 24 N BLO AND LOOM 60 9	MAY	TEMBER 1,2006	
1 -	31. Date filed (Month, Day, Year) 32. Registrar's Signafure CED 0 7 2006	MD 212	0 7	

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 28244 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 30, 2006 Physician August 9:00 a M SARAH VIRGINIA HOLTER /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Columbia Brighton Gardens If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Oct 12, 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□ M 2□ F 84 Yrs. 1921 Maryland Director 215-18-2213 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28e-f show od 2 should be filed within 72 hours after death with the Maryla th and Mantal Hygiene. 27 Is marked other than "natural", or Itams 23a or 28e-f shov traumatic event, its Macifical Exonolism chair be natified at 1 √Yes 2 No Columbia Howard Maryland Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21045 7110 Minstrel Way #225 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 245 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ White 3XVidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Grade 11 Office Administrator U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Allen Magaha Rosa Eader 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 si iment of Health and tant: If Item 27 is i jury or other traur / daughter 10213 Red Lion Tavern Court, Ellicott City, MD Judith Pruitt 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c, Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If It any injury or o 1 Burial ZCremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) West Arundel Crem. 09/01/2006 Odenton, Maryland 21. Signature of Funeral Service licensee 22 Name and Address of Facility Donaldson Funeral Home, P.A. M00160 audele Talbott Avenue Laurel, Maryland 20707 Z3a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ischemic Cardiomyopathy disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Hypertension Due to (or as a consequence of) P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 24 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached to 9 🗆 Unknown 2 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2XXIo 3 ☐ Probably 4 ☐ Unknown Renal Insufficiency 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Osteoporosis autopsy performed? page 2 certificete 2KNO 1 Yes XX No Division of Vital director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Assisted Other: 4 Nursing Home 5 Residence 6 Hother (Specify) Living Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2√XNo After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Padmoye August 31, 2006 D 24174 20 30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print) 7350 Van Dusen Road #380 Laurel, Maryland Padmaja S. Udapi, M.D. 20707-5231 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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ORIGINAL

State of Maryland / Department of Health and Mental Hygien 200528245 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 2,2006 **Physician** BETTY HEGE 7:10P M Μ. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HIGHLANDTOWN BALTIMORE 437 PEMBROOKE BLVD 8. Date of Birth (Month, Day, Year) 7 - 1 - 1 9 4 1 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 213-66-5899 65 Yrs. Months Hours Min 1 □ M 2 1 TF GERMANY Director Usual Residence of Decedent Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "natural", or Itams 23s or 28a-f show The Medical Evaniner must be notified at BALTIMORE HIGHLANDTOWN MD 1 □Yes 2 No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 437 PEMBROOKE BLVD 21224 U.S.A. death Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ Mo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. Iam 27 is marked othar than "natural", or Ita 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify:WHITE þ 3 Widowed 4 Nivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) WAITRESS RESTAURANT 17. Father's Name (First, Middle, Last)
UNKNOWN 18. Mother's Name (First, Middle, Maiden Sumame) PONGRAC UNKNOWN (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 thent of Health a tant: If itam 27 is GERRY HEGE/SON 437 PEMBROOKE BLVD BALTIMORE, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Removal from State permit. Page Department of Important: If any injury or once. 9-5-2006 METRO CREMATORY CATONSVILLE, ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVENUE ROSEDALE, MD 21237 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final Priysician helastalic mall cold MONTY disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury Due to (or as a consequence of) Examine certificate be executed the burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medicai use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached the 9 Unknown 9 Unknown þ requires that signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → No 24a. Was an certificate has b autopsy performed? (es 2 2 No 1 Yes Attanding Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 XResidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 28b. Time of 28d. Describe how injury occurred 27 Manner of Death After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide in by ō To the Hospital 24 hours a 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of comilier Hyucas Ma who completed cause of de to (Am 23a) (Type, Print) 30. Name and address of person MILHORL Eusten 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State 2006 SEP 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9 0 0 6 28246 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician Aug 30, 2006 8:20p Wilbert L. Howell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Raltimore** Joseph Richey Hospice, Inc. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 9, 1943 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 ☐ F No. Carolina 62 238-64-8446 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County rthen "natural", or items 23s or 28s-f ehov the Medical Examinar must be notified at 1 Yes 2 No **Baltimore** N/A Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1203 Woodyear Street 21217 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 🗷 No Specify: Black Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Gas & Electric Company College (1-4or 5+) Elementary/Secondary (0-12) Laborer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Howell Frank Howell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1203 Woodyear Street Baltimore, Maryland 21217 Trina Burroughs 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Neurial 2 Cremation 3 Removal from State Department c Important: If any injury or once. 09/08/06 Baltimore, Md. Western Cemetery 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licens 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter thodi rease shock, or heart failure. L ath Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death e, or complications that caused the d List only one cause on each line. Immediate Cause (Final 10 months Metastatic **Physician** tensillar caucer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 Yes 2 No cancer , remission Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 1 Yes 2 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Inputiont Other: 4 Nursing Home 5 Residence 6 Nother (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Hospice

/Medical Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, been signed by the should be detached certificate director After thi Director: / within 24 hours after To the Funeral Dire within 24

filed within 72 hours after death with the Maryland Hygiene.
Mer then "natural", or Items 23a or 28a-1 ehow

ges 1 and 2 should be filed to the alth and Mental Hygie If Item 27 is marked other I

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Baltimore, Maryland 21215-0036

Certification:

Medical

State Registrar

1 ☐ Yes 2 ☐ No 27. Manner of Death

1 Natural

2 / Accident

3 Suicide

29a. Certifier

4 Homicide

5 Pending

6 Could not be

1 🔾 crititying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johns

0

28a. Date of Injury (Month, Day Year) 28b. Time of

MD

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0058893 Hespotal September 2006

28f. Location (Street and Number or Rural Route Number. City or Town, State)

29d. Date signed (Month, Day, Year)

Maryland 21224

28d. Describe how injury occurred

Baltimore

Browner 11ene 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

Hep Kins

DHMH 17 Rev 1/2001

		State Registrar 1. Decedent's Name (First, M.)	iddle. Last)	-		Cel	tificate	, 01 L	Catri]	2. Date of Deal			3. Time of Death
Physicia		Haze1	,	Ray		H	leineg	oer		9	Month Septembe	Day	Year 2006	09:00 P
/Medic		4a. Facility Name (If not instit	ition, give s		ber)				Location o				nty of Death	
	Ť	Mariner Heal	th at	North	Arunde	1	G1e	n Bu	rnie			Ann	e Aru	ndel
uneral irector		5. Social Security Number 217-01-6203	6. Sex	M 21XF	'. Age (In yrs. 88			Days Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Aug. 31	Year) ,1918	9. Birth Cou	place (State or Foreig intry) MD
1025		Usual Residence of Deceden			10c Cit	y, Town or Lo	cation							10d. Inside City Limit
-fehor	tor		Arun	del		evern	02(10)1							1 ☐ Yes 2X N
or 28e	Director	10e-Street and Number					10f. Zip (Code			1	0g. Citizen	of What Cou	intry?
23a	rai	7665 Old Tel					211					U.S		
intering any went in years. Intering 18 marked other then "neturel", or flems 23a or 28e-f ehow other traumatic event, the Modical Examiner must be notified at	by Funerai	11. Marital Status 1 Never Married 2 🛣 3 Widowed 4 Divor	Marned	 Was Deced Armed Ford Yes 2 If Yes, Give Year or Dat 	ces? 2 <u>™</u> No		Was Decede f Yes, speci 1 ☐ Yes 2		spanic Origin, Mexican Specify:	jin? (Spe , Puerto f	cify Yes or No- Rican, etc.)	E	Race - Ameri Black, White cify: W	
neture lical E	ted	15. Dece (Specify only hi	dent's Educ			16a. Dece	dent's Usual	i Occupa	tion	of working	na	16b. Kind o	Business/Ir	ndustry
rand metter rygnere. 7 Is marked other then " fraumatic event, the Max	Completed	Elementary/Secondary (0-1		College (1-	4or 5+)		kind of word DO NOT use emake:					Own	Home	
other ent, th	Be Co	17. Father's Name (First, Mid	dle, Last)			22021			18. Mothe	r's Name	(First, Middle,			
rked tic ev	ToB	Joseph Benson	Ray	Sr.					Lola	Hawk	ins			
le ma		19a. Informant's Name/Relat					•				I Route Number			
permit. Pages 1 end 2 Department of Health Important: if Item 27 i any injury or other tru		Mr. Harry Hei 20a. Method of Disposition	negge	L-nusba	20b. F	lace of Dispo	sition (Nam	e of		D	d Sever		ry Lanc on - City or T	
		1 🔀 Burial 2 □ Cremat 4 □ Donation 5 □ Othe	on 3 ⊟R	emoval from S	tate	emetery, crer eadowr:	-		" ¦S	ept. 200		Elkr:	ldge,	MD
portar y injur		21. Signature of Furera Sur		е					s of Facility		gleton			
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es been signed by the ettending physicien end signed by the ettending physicien end should be detached for use as the burial-transit		234. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition	e, or complie List only on	eations that ca e cause on ea	used the deat ich line.		er the mode					est,		Approximate Interval Between Onset and Death
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ned by the ettending ph detached for use as th	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	2:		rth 2 ☐ Feta ant at time of d	Ideath 3	Ectopic pre					23d.	Date of deli- Month	very Day Year
s been signed by should be detai		Part II. Other significant cor		tributing to de		ulting in the u	nderlying ca	iuse give	in in Part I.			bacco use d		the cause of death?
shoul	Completed by	ALO		Notion				-			24a. Was a	in 24	b. Were aut	opsy findings availat
200	omp	- KIVION	(10)	70-110-							autops perfor	med?	prior to codeath?	ompletion of cause o 2 ☑ No
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r death.	To B	examiner? 1 ☐ Yes 27X No	Н	_		ER/Outpatier			4/21/140	rsing Hor	ne 5 Resid	ence 6 🗆	Other (Spec	ify)
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or: After this ce the funeral dire			euld not be termined		of Injury - At higg, etc. (Specif		reet, factory,	, office		1	28f. Location (S City or Tow		imber or Rui	ral Route Number,
and by the funeral dire	ertific			ician: To the							and due to the c ed at the time, d			
6 Funeral Director: After this ce	dical Certification:													
within 24 nous and obain. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical Certific	(Check only 2 Med one) 29b. Signature and title of ce	rtifier	ner: On the ba	er stated.		-	License	105	21	_	Sept	mber	5,2006
within as trouts arel beauti. To the Funerel Director. Affet this or completely filled in by the funeral dire	Medicai Certific	(Check only 2 Med one) 29b. Signature and title of ce	rtifier	mer: On the ba	er stated.	·	-	D-4	105	21 31TA	L DRIV	Sept	mber	5,2006

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryla	nd / Depa	artment of Hertificate of L	ealth and M Death		ene2006	28248
	Physici	an	1. Decedent's Name (First, Middle, Last) Alma Elizab	eth Hofme	eister			2. Date of Death Month	Day Year	3. Time of Death 5 50 A M
1	/Medio Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death	Sept	4c. County of Death	
				Baltimore			re Lity		N/A	
	Funeral Director		220 /1 0301		s. last birthday) 6 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y) 9 – 29 – 19	ear) Cour	place (State or Foreign htry) cyland
	ow III		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation			1	10d. Inside City Limits
	a-f eh	ctor	Maryland N/	A		Bal	timore			M Yes 2 □ No
	or 28	Dire	10e. Street and Number	_		10f. Zip Code	4000	10g	. Citizen of What Cour	
>	eath v	erai	2211 W. Rogers	Avenue 2. Was Decedent Ever in	U.S. 13.	Was Decedent of His	1209	ecify Yes or No-	14. Race - Americ	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23s or 28s-f show other traumatic event, the Medical Exercites runal ke notified at	by Funeral Director	1 Never Married 2 Married 3XXIII dowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		fYes, specify Cubar 1 ☐ Yes ※XXNo	Specify:	Rican, etc.)	Black, White,	
2-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occupa kind of work done d DO NOT use retired)	tion uring most of work	ing 16	6b. Kind of Business/In	dustry
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	il Hygi other	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Ma		
ylar	d 2 should be filled within h and Mental Hygiene. 7 is marked other than "traumatic event, the Mes	To E	William Gardner				Cece			
Maryland	d 2 sh th and th and 7 is m traum		19a. Informant's Name/Relationship (Type Walter L. Hofme						City or Town, State, Zip rinity, I	-
	s 1 and 2 f Health item 27 i		20a. Method of Disposition	206	. Place of Dispo	esition (Name of matory or other place			c. Location - City or To	
imo	Pages nent of I		¥ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State D	cuid R	idge Cem	etery 9	/7/06	Pikesvill	le, MD
Baltimore,	permit. Pages 1 and Depertment of Health Important: if Item 27 eny injury or other tr once.		21. Signatur Funeral Servio Livense	erpenter	- Bi	Name and Addres Urgee-He 631 Fall	s of Facility nss-Sei s Road	tz Fune Baltim	ral Home, ore, MD	Inc. 21211
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	e cause on each line.	ath. Do not ent	er the mode of dying	, such as cardiac	or respiratory arres		Approximate Interval Between Onset and Death
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	A CUTE MIL	jocard	ial Infa	nction	4		1 hr.
	Examiner		WO TO THE STREET OF THE STREET	Due to (or as a cons	aduence of):	٧				
	p #	iner	Securitary list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):					
	and and	Examiner	that initiated events cresulting in death) Last	Due to (or as a cons	equence of);					
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9	rtificat ng phy s as the	Medi	IF FEMALE:		r **					
Вох	Attending Physicien: The law requires that the death certific death. sctor: After this certificate has been signed by the attending report the tuneral director, page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pred 1☐Live birth 2☐Fo 4☐Pregnant at time o	etal death 3	Ectopic pregnancy			23d. Date of delive Month	ery Day Year
P.O.	the de y the a	ysic	1 □ Yes 2 ☑No 9 □ Unknown	9☐ Unknown	rdeath 5L	Other (specify)				
	s that gned b	by Pt	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	nderlying cause give	n in Part I.		cco use contribute to the	
Records,	w require been sig should b	ted	Hyperlension	•				1 🗆 Yes	2 ☑No 3 ☐ Prot	pably 4 □Unknown
3ec	e law has b	Completed	V			·		24a. Was an autopsy performe	24b. Were auto prior to co death?	psy findings available impletion of cause of
tal	in: Th ificate or, pag	e Co	25. Was case referred to medical				26 Place of Deat		No 1 ☐ Yes	2□ No
Division of Vital	lysicis lis cert direct	To B	examiner?	ospital: 1 √Inpatient 2	☐ ER/Outpatier	nt 3 DOA Othe	r		ce 6 Other (Specif	(y)
0	ing Ph After th uneral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time o Injury	Work		28d. Describe how	injury occurred	
isio	i or Attendi after death. Director: A I in by the fu	licati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - A	home farm str		′es 2 □No	28f. Location (Stre	et and Number or Rura	al Route Number.
οį	al or A safter i Direct	Certification:	4 ☐ Homicide determined	building, etc. (Spe	cify)	out, radiory, difficu		City or Town,		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely tilled in by the funeral director, page 2	Medical C	(Check only 2 Medical Examination)	sician: To the best of my kner: On the basis of exam and manner stated.	ination and/or in	vestigation, in my op	inion, death occur	red at the time, date	e and place, and due to	etated. to the cause(s)
	To the To the comp	×	29b. Signature and title of certifier			29c. License	number	290	d. Date signed (Month,	Day, Year)
	1		10shta run	man Mp		KESC	, 000	Se	7,200	06
	y		30. Name and address of person who co	mpleted cause of death (I	tem 23a) (Type,	Print) 101 DITa	IN B	allen	OLI	
	Sta		29b. Signature and title of certifier Toshita Kun 30. Name and address of person who co Toshita Kun 31. Date filed (Month, Day, Year)	32 Registrar's Sig	gnature	- M. I	- (
	Regist	rar -	0 M 2006	MARIE	18 LION	3/03/4				

Pr. Rnown as Alma Hopmeister.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 28249 State of Maryland / Department of Health and Mental Hygiene [] [] [6] 1- For Amend item#5, perFH, G859, 9/18/06 TT Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) AUGUST 2006 **Physician** th 19:14PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SAINT AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** M 2□ F CX. -38-525 00 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State ehow W d 2 should be filed within 72 hours after death with the Maryla. It and Mental Hygiene. Ty? Is marked other then "naturel", or Iteme 23e or 28e-f ehov traumatic event, its itsuical Examinant must be routified as TIMORR 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 100 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ineer ENG inical 18. Mother's Name (First, Middle, Maiden Sumame) ame (First, Middle, Last) permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event <u>once.</u> Be OSe ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nformant's Name/Relationship (Type, Print) Innette 3201 . Mo BaITO Brighton 20b. Place of Disposition (Na)ne of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2. ☐ Cremation 3 ☐ Removal from State Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21 Sign pur of Funeral Service Licensee towell f Facility towell 4600 LIBERTY 21201 119h4 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SPONTANEOUS INTRACRANIAL **Physician** MKNOWN /Medical Due to (or as a consequence of): Examiner HYPERTENSION WHENCESH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sicion and burial-transit MELLITUS unknown Due to (or as a consequence of): STAGE RENAL DIFEASE unknown Physician/Medical use as the been signed by the attending should be detached for use as Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant NIA 3 Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 5 Other (specify) NIA 9 Unknown o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, VASCULAR PINEATE 3 Probably 4 Nnknown 1 Tes 2 No Completed NON COMPLIANCE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s hes autopsy performed 1 Yes 2 No certificate 1 Yes Vital 25. Was case referred to medical examiner? director, Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 To the Hospitel or Attending Phys within 24 hours after death.

To the Funerel Director: After this completely tilled in by the funeral directors. this 27. Manner of Seath 1 XNatural 2 ☐ Accident 28a. Date I Injury (Month, Day Yeer) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signafure and title of certifier 29c. License number wildo AUGUST 29th, 2006 P18611 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAG DALENA 7 31. Date filed (Month, Day, Year) TARNOWKA 900 CATON AVENUE, BALTIHORE MD 2/219 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

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2006

		•	For Stete Registrer	State of Maryland /	Department of H Certificate of L	ealth and Me D <i>eath</i>	ntal Hygiei		28250	
ı	Physici	an	Decedent's Name (First, Middle, Last)			2	Date of Death	Day Year	3. Time of Death	
	/Medic	al	4a. Fecility Name (If not institution, give str	Halterma	Ab City Town or	Location of Death	9	1 2006 4c. County of Death	0800 AM	
	Examin	er	Unversity of Mary la	al Modred	autor B	altimore		N/	A	
	Funeral Director		5. Social Security Number 6.56x 218-68-4853	7. Age (In yrs. last to 47	Yrs. If Under 1 Year Months Days	Hours Min.	. Date of Birth (Month, Day, Ye 1/21/195	ar) Cou	place (State or Foreign intry) and MD	
	and		Usual Residence of Decedent 10a. Sfate 10b. County	10c. City, To	own or Location				10d. Inside City Limits	
	Maryl	tor	MD Garrett	0akla	and				1X Yes 2 No	
	th the	Director	10e. Sfreet and Number	Junio	10f. Zip Code		10g.	Citizen of What Cou	untry?	
	ath wi		250 N. Bradley Lan		21550			USA		
_	Items Inerr	Funerai	11. Marital Status 12 Never Married 2 Married 12	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No	13. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Speci n, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Amer Black, White		
5-0036	n 72 hours after death with the Maryland "neturel", or Items 23a or 28e-f e-how aviral Examinar must be multified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No	Specify:		Specify: W	hite	
ر ک		Completed	15. Decedent's Educa (Specify only highest grade	tion 16	Sa. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	ation furing most of working	16b	. Kind of Business/I	ndustry	
[2]	within	фщ	Elementary/Secondary (0-12)	College (1-4or 5+))		Restaurant		
2	Hygi Hygi Ther	0	17. Father's Name (First, Middle, Last)		Cook	18. Mother's Name (i			Ţ.	
/lar	ould be Mental arked c	To B	Edward L. Nutter			Betty Si	nes			
Maryland	d 2 should th and Mer t7 le marke traumatic		19a. Informant's Name/Relationship (Type		9b. Mailing Address (Street a				ip Code)	
	Pages 1 en lent of Heel nt: If Item 2 ry or other		Granville Halterma 20a. Method of Disposition	20b. Place	250 N. Bradle; of Disposition (Name of	Dat		U 2155U . Location - City or I	Town, State	
altimore,			1 ☐ Burial 2 【XCremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		tery, crematory or other place Crematory	9/2/2		altimore,		
Balt	permit. Depertm Importe eny Inju		21. Signafure of Funeral Service Licensee	14.00.	22. Name and Addres	36		Funeral H	ome, P.A.	
			23a. Part 1 Enter the disease, or complication	ations that caused the deat). Di	3111 Mounta o not enter the mode of dying			MD 21122	Approximate	
	Physician		shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.	Change K	000/ 1	Eiline		Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequenc	te of):	1	- WUVE			
4	ZAGIIIIIO.	er	Sequentially list conditions, b. if any, leading to immediate	Due to (or as a consequence	te of):	Mise	ne-			
	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,						
60,	ificate be executed physicien and as the burial-transit		resulting in death) Last	Due to (or as a consequence	ce of):					
98/89	ficate physics the	edical	d.							
ROX	ih certi ending r use a	M/W	23b. was decedent pregnant	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel dea	ath 3□Ectopic pregnancy			23d. Date of deliv		
	The law requires that the death certificate has been signed by the attending is agge? should be detached for use as	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of death				Month	Day Year	
J.	that it		Part II, Other significant conditions conti	ibuting to death but not resulting	g in the underlying cause give	en in Part I.	23e. Did fobacc	co use confribute to	the cause of death?	
ras	w requires that been signed b should be deta	ed by	Hyportenson,	Polyagstre	Lover pos.	eere	1 🗆 Yes	2□No 3□Pro	bably 4 Unknown	
မင္မ	law re las be	ompieted					24a. Was an autopsy	prior to o	opsy findings available ompletion of cause of	
<u>الله</u>		O					performed 1 ☐ Yes 2,20	? death?	2 No	
\ <u>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</u>	Attending Physician: r death. sctor: After this certific by the funeral director.	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital:	Outpatient 3 DOA Othe	26. Place of Death (0 DONA (Care	4.0	
ō	g Phys er this eral di	-	27. Manner of Death	28a. Date of Injury 28b	o. Time of 28c. Injury	4 LI Nursing Home	d. Describe how i	e 6 ☐Other (Specinjury occurred	iry)	
Ö	auth. or: Aft	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)		Yes 2 □ No				
Division of Vital Records,	To the Hospital or Attending Phys within 24 hours atter death. To the Funers! Director: After this completely filled in by the funeral di	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28	f. Location (Stree City or Town, S.	t and Number or Rui tate)	ral Route Number,	
	papital hours uners! y filled		29a. Certifier Certifying Physi	cien: To the best of my knowled	dge, death occurred at the tim	ne, date and place, an	d due to the cause	e(s) and manner as	stated.	
	the Ho lin 24 the Fu	Medicai	one)	er: On the basis of examination and manner stated.						
1	5 # C 0	~	29b. Signature and title of certifier		29c. License	6147	29d.	Date signed (Month		
	ıĹ		30. Name and address of person who com			1710		4/1101	6	
	7		William L. Chiu,	p. 3-2 S. Gre	eene St. B	alt:more	, ~0 0	1061		
	Sta		Milliam L. Chiu, n 31. Date filed (Month, Day, Year) SEP 0 7 200	32. Registrar's Signature	Acast.					
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Registrar

DHMH 17 Rev 1/2001

SEPTEMBER

JOHNSON

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2006 28252 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** e LLU 8:44 AM conard Acust 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltmore Baltmore Hospital of If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 M 2 □ F Yrs. 241-38-377 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f ehow r than "natural", or iteme 23s or 28s-f ehov the Medical Examiner must be notified at 1 Nes 2 No Funeral Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number dale Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No fl Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes No Specify: Specify: Hac δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of, Business/Industry 15. Decedent's Education (Specify only highest grade completed) SelF other than " Elementary/Secondary (0-12) Coflege (1-4or 5+) umber 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) in and 2 should be fit Health and Mental H ume 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: if item 27 is any injury or other trau daughter 320 md, bras Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 200. Location · City or Yown, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 06 memi Hark 4 Donation 5 □ Other (Specify) 21. Six Jure of Funeral Service Licensee Beetoing 212 Tre 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Physician G-liobestama /Medical Due to (or as a consequence of): Examiner Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, physician s the burial Certification; To Be Completed by Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death signed by the at d be detached for 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 Yes 2 No 3 Probably 4 Donknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No s certificate has the 1 Yes 2 No Division of Vital 25. Was case referred to medicaf examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After thi
completaly filled in by the funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number KES -000 Bust 31 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Etherington Sizani 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 28253 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 09 10:47 PM 04 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Boyview Med Ctr Baltimare or 1 Year | If Under 24 Hrs. N/A6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days 1**™**M 2□F Hours Min 215-07-9598 86 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Iteme 23a or 28a-f ehow tre Medical Examinar must be notified at 1 Tyes 2 No Director MD Baltimore Co. Middle River 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 43 Tearose Drive 21220 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Mayes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: δ Specify: 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If I tem 27 Ie marked other then eny injury or other traumatic event, If a Ms Coltege (1-4or 5+) N/ALongshoreman Shipping 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Felix Kropp Antoinette Ferenc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43 Tearose Drive Cecelia Kropp - Wife Middle River, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St.Stanislaus Cem. 9-9-2006 Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, MD 21222 202 Part1. Enter the disease, or complicate shock or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastases to brain **Physician** -/Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner anding physicien end use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No page 2 should be detached for Month Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed?
Yes 2, No this certificate has 2□ No 1 ☐ Yes 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eastern Ave., Bultimore, MD 21224. 4940 MD Kni 31. Date filled (Month, Day, Year) Registrar's Signature 32 State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 28254 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year IDA MAY LOOR September 2, 2006 12:01 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles County Nursing Home LaPlata Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗓 F 98 Yrs Director 213-38-1170 8/8/1908 Washington, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "natural", or Items 23s or 28s-f show vent, the Medical Examiner must be notified at 1 X Yes 2 No Mary land Charles LaPlata Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1398 Redwood Circle 20646 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: White 3 X Widowed 4 □ Divorced leted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Compl Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk National Geographic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked Philip J. Barbour Ida G. Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If Itam 27 is eny Injury or other trau once. James A. Loor, Sr. Son 1398 Redwood Circle, LaPlata, Maryland 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 9/7/2006 Suitland, Maryland 21. Signature of Furreral Service License 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Mass /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of and I-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of). physician a s the burial-Records, P.O. Box 68760, Physician/Medical attending for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy lindings available prior to completion of cause of death? s certificate has the performed' 1 🗆 Yes 2 X No 2 No Division of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No ို 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After thi 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death I Diractor: A 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funaral Diract completely filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 106 Name and address of person who completed cause ol death (Item 23a) (Type, Print) than (V Nursing Jay an 31. Date filed (Month, Sal Pear) 2006 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 28255 State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 4 2006 Robert Clifford Linton 8:00 AM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Howard Columbia Harmony Hall

Physician /Medical Examiner

	Funeral Director		5. Social Security Number 267–42–6396 Usual Residence of Decedent 10a. State 10b. County	≹M 2□F	72 0c. City, To	Yrs.		Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D June	rth av Year 4,	1934	9. Birth	nplace (State or Foreign unity) rida 10d. Inside City Limits
	Maryis f eho	ō	Maryland Howard			enelo									1 ☐ Yes 2 XNo
	the the 28a-	rect	10e. Street and Number				10f. Zip (Code				10g. C	itizen of V	Vhat Co	untry?
	3a or	ā	14219 Meadow Lake	Drive				2173	37			Ţ	J.S.A		•
10	be filed within 72 hours after deeth with the Maryland tal Hyglene. d other then "natural", or Items 23e or 28e-f ehow event, the Medical Examinar must be notified at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 🔀 Married	12. Was Decedent Eve Armed Forces? 1 √Yes 2 \(\) No							cify Yes or N Rican, etc.)	0-		e - Amer k, White	ican Indian, , etc.
93	al, o	þ	3 ☐ Widowed 4 ☐ Divorced	1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:		1	I□Yes 2	⊠ No	Specify:				Specify	Bl	ack
5-0	72 ho natur	eted	15. Decedent's Edu (Specify only highest grade		16	(Give	lent's Usual kind of work	done (during mos	t of workin	ng	16b.	Kind of Bu	isiness/l	ndustry
21215-0036	should be filed within of Mental Hyglene." marked other then " imatic event, the Mer	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life. L	no not use rber	retired				F	Hair		
	be filed tai Hygi d other	Be	17. Father's Name (First, Middle, Last)								(First, Middle			Θ)	
yla	should be and Mental marked o	2	Samuel Linton								e Harr				
, Maryland	2 6 5 2		19a. Informant's Name/Relationship (Ty, Eloise Linton (W	rpe, Print) life)			-				e Glen				ip Code) nd 21737
Baltimore,			20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 ☑A 4 □ Donation 5 □ Other (Specify)	temoval from State	ceme	tery, степ	sition (Name natory or oth Park	er plac		9-9-2	ate 2006		Location - mi, I		Town, State ida
Balti	permit. Page Depertment of Importent: if any injury or once.		21. Signature of Funeral Service License	66	>	₩ 5	itzke 555 Tv	Addres Fur vin	s of Facilit eral Knoll	"Home Ls Ro	s, Inc		oia,		
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused th	ne death. D	o not ente	er the mode	of dyin	g, such as	cardiac or	r respiratory a	arrest,			Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a c	de	age	- res	ra	1 6	arli	ul				Onset and Death
68760, 🔏	eath certificate be executed attending physicien and for use as the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	Due to (or as a control of the contr	alre	li	d	en	ren	lea					
P.O. Box 68	equires thet the death certificate be executed some signed by the attending physicien and could be detached for use as the burial-transit	ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	t3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tin 9 ☐ Unknown	☐ Fetel dea		Ectopic pre Other (spe						23d. Date Mor		very Day Year
σ.	thet the	by Ph	Part II. Other significant conditions cor	ntributing to death but	not resulting	g in the ur	nderlying ca	use giv	en in Part I		23e. Did	tobacco	use contr	ibute to	the cause of death?
ords,	w requires thet s been signed b should be deta	ted b									10	Yes :	2 2 (No	3 🗆 Pro	obably 4 □Unknown
of Vital Reco	he law re e has bee age 2 sho	Complete										omed?	P	rior to c leath?	copsy findings available ompletion of cause of
ta	sician: The la certificete ha irector, page 2	0	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only	one)	10		20110
₹ V	Physici this cer al direc	ToB	examiner? 1 ☐ Yes 2 No	tospital: 1 Inpatient	2 ☐ ER/	Outpatien	t 3 DO	Oth	er: 4 NL	ursing Hom	ne 5 ☐ Res	idence	6 □Othe	er (Spec	ufy)
ion o	Attending Physician: The law r r death. ector: After this certificete has be by the funeral director, page 2 sh		27. Manner of Death 1. ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day)		b. Time of Injury	M 28	c. Injur Wor	yat k? Yes 2□		8d. Describe	how inj	ury occurr	ed	
Division	al or Atte s efter de i Directo id in by th	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.		, farm, str	eet, factory,	office		2	8f. Location City or To			er or Ru	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical (29a. Certifier 1 Certifying Physical Control only 2 Medical Examination	sician: To the best of and manner state	xamination	dge, death and/or inv	occurred a vestigation,	t the tin	ne, date an pinion, dea	nd place, a th occurre	nd due to the	cause(, date ar	s) and ma nd place, a	nner as and due	stated. to the cause(s)
	To th withir To th	Me	29b. Signature and talle of certifier 30. Name and address of person who co	Mo	Parada		29c.	Licens)5	08	70		29d. D	ate signed	Month	1. Day. Year) 1 5 Th 2001
	5		30. Name and address of person who co	ompleted cause of dea	ith (Item 23	a) (Type,	Print) Be	U	Lan	re_	Cla	uli	sid	le.	mDainzo

State Registrar 31. Date filed (Month, Day, Year)

32, Registrar's Signature

	1. Decedent's Name (First, Middle, La			Certificate of	Dealli	2. Date of De	Reg. No.	6 28256			
ian	1. Decedent's Name (First, Middle, La	Anna T. Lis	5			Septem	Day	Year 006 11:00 A.M.			
ical ner	4a Facility Name (If not institution, given				4b. City, Town, or Lo						
CI	Future Care - Ch	nesapeake			Arnold		Anne	Arundel			
	,		yrs. last bir	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	Birthplace (State or Foreign Country)			
	212 32 6403 Usual Residence of Decedent	1LJM 2LAF 72		Yrs.		June 3	0, 1934	Poland Poland			
	10a. State 10b. County	10	c. City, Tow	n or Location				10d. Inside City Limits			
	Maryland Anne Ar	undel	Glen	Burnie				1 ☐ Yes 2 🖾 No			
	10e. Street and Number			10f. Zip Code			10g. Citizen of Wi	hat Country?			
	1 Idlewood Str			210			U.S.	Ai ladi-			
	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No	r in U,S.	13. Was Decedent of H If Yes, specify Cuba	fispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.) Black, Whi		- American Indian, , White, etc.			
-	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:			White			
	15. Decedent's E	ducation	16a.	Decedent's Usual Occup	ation	ina	16b. Kind of Bus	iness/Industry			
	(Specify only highest gri	College (1-4or 5+)		(Give kind of work done life. DO NOT use retired	d)	9	State of Tax Div	Maryland			
	12th		A	uditor	19 Mother's Nam	e (Firet Middle					
	17. Father's Name (First, Middle, Last Barth	•					ther's Name (First, Middle, Maiden Surname) Maria Dalidowicz				
	19a. Informant's Name/Relationship			o. Mailing Address (Street				State, Zip Code)			
	Rose Lis / Daugh		2	72 Pertch Ro	ad Seve	erna Par	k, Maryl	and 21146			
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		20b. Place of cemete.	f Disposition (Name of ry, crematory or other place	ce)	Date 20c. Location - City or Town, State 9/8/06 Baltimore Maryla					
	re, Maryland										
	rvice, P.A. Maryland 21225										
	I				ng, such as cardiac			Approximate Interval Between Onset and Death			
	Immediate Cause (Final disease or condition resulting in death)			Cas cul (a)				Interval Between			
II EXAIIIITE	disease or condition resulting in death)	Due b.	e to (or as a	as cula				Interval Between			
	disease or condition	b. Due	e to (or as a	consequence of):				Interval Between			
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DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month; Day, Year)

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiens 28257 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 1550 Aug Randolph Lockett 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Maryland Medical Clinter

7 Ana In vis. last birthday) If Under If Under 24 Hrs. 8. Date of Birth
Hours Min. Month, Day, N/A University of 5. Social Security Number 219 - 28 - 5268 6. Sex Birthplace (State or Foreign Country) **Funeral** 10M 20 F Months Days Yrs. Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Exercises. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 608 Nautilus Avenue 21225 Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (2) Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver 12th Yellow Bus Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Lockett Mary Dise ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lockett / wife 608 Nautilus Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State Bayview Crematory Baltimore, Maryland 9/2/2006 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 come romuseur 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hypotension Physician 4 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner atrial fibrillation y Call Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is listed as exercise. Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the deeth certificate be executed attending physician and for use as the burial-transit esornageal carcinomi that initiated events resulting in death) Last Due to (or as - onsequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Cther (specify) cate has been signed by the page 2 should be detached 9☐ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? À 3 Rrobably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy this certificate ŽS 1 ☐ Yes 2 ☐ No 1□ Yes : After this certification of the state of t 25. Was case referred to medical examiner? 26. Place of Death (Check only one Dther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Sepatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending within 24 hours after death.

To the Funaral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8/29/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMBE 5 32. Registrar's Signature 1 - Ca 2124 31. Date filed (Month: Day, Year) State Registrar

DHMH 17 Rev 1/2001

Body not recovered Court order issued by: Judge Evelyn Onega Cannon OC# 24-C-06-2063 4 5....

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 15

28258

		1 - State Registrar		Ce	rtificate of	Death	Re	2 0 0 0	2023
		1. Decedent's Name (First, Middle, L.	ast)			-	2. Date of Death	1	3. Time of Death
Physicia /Medic		Garfield	Ja	mes	Me	ekins	March	7, 2006	N.
Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, o	or Location of Death		4c. County of Death	
		Baltimore City (Court Order		Bal	timore Cit	V		
Funeral Director		5. Social Security Number 6. 214-07-9072 Usual Residence of Decedent	1¥TM 2□E	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec, 21		place (State or Foreig ntry) aryland
or death with the Maryland tems 23e or 28e-f ehow	tor	10a. State 10b. County	10c.	City, Town or Lo					10d. Inside City Limit
288 100	Director	MI) 10e. Street and Number		Baltim	ore City		10	og. Citizen of What Cou	ntry?
3s or		804 Cooks Lane	2		21229			USA	
items 2	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13.		Hispanic Origin? (Spec an, Mexican, Puerto F	offy Yes or No-	14. Race - Ameri	
ours afte		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 🕅 Yes 2 🗍 No If Yes, Give Year or Dates: 194		1 ☐ Yes 2 No		rican, etc.)	Specify: Bla	ack
be filed within 72 hotal Hygiene. Id other than "nature event, I'm Moulca	Completed by	15. Decedent's E (Specify only highest gi		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of workin	1	6b. Kind of Business/Ir	ndustry
illed with Hygiene other the	Cor	X				Y			
2 should be fit and Mental H is marked off	To Be	17. Father's Name (First, Middle, Las Hansel	Meeki	.ns		18. Mother's Name Mary	(First, Middle, M	faiden Sumame)	
s 1 and 2 should f Heelth and Mer Item 27 is marke other treumatic		19a. Informant's Name/Relationship Rubie Meekins	daughter	810	Wedgewo	od Rd, Bal	timore,	City or Town, State, Zij MD 21229	o Code)
Pages 1 ar ment of Hee ant: If Item: ury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 (4 Donation 5 Other (Spec	☐Removal from State	,	sition (Name of natory or other pla	ce) Da		20c. Location - City or To /a	own, State
permit. Pages 1 and 2 should be filed within 72 hours aff Department of Heelih and Mental Hygiene. Important: if Item 27 is marked other than "natural", or eny injury or other treumatic event, It a Meulcal Examplence.		21. Signature of Funeral Service Lice	ensee	22	2. Name and Addre	ess of Facility			
Physician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused the do y one cause on each line. Undetermi Due to (or as a cons	.ned	er the mode of dyi	ng, such as cardiac or	respiratory arre	st,	Approximate Interval Between Onset and Death
	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons						
ath certi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of predictions of the state of the	etal death 3L	Ectopic pregnanc Other (specify)	у		23d. Date of delive	ery Day Year
quires thet the de n signed by the e uld be detached i	٥	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.	1	acco use contribute to t	
for Attending Physician: The law requires I effer death. Director: After this certificate has been signe I in by the funeral director, page 2 should be or	Completed						24a. Was an autopsy perform	24b. Were auto prior to co death?	opsy findings available impletion of cause of
ien: rtifice stor, I	Bec	25. Was case referred to medical				26. Place of Death			2010
Physician: this certific ral director,	10	examiner? 1X Yes 2 □ No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	t 3□ DOA Ott	ner: 4 Nursing Hom	e 5 Resider	nce 6 Other (Specia	wcaurt order
Attending Pt r death. ector: After th by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident rinvestigation		28b. Time of Injury	Wo			w injury occurred	
s efter de ei Directo ed in by ti	Certification:	3 ☐ Suicide 6 🖄 Could not l 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ocify)	eet, factory, office	2.	8f. Location (Str. City or Town,	eet and Number or Run State)	al Route Number.
To the Hospital or Al within 24 hours efter or To the Funerei Direct completely filled in by	edicai	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	thysician: To the best of my laminer on the basis of exam and manner stated.	knowledge, deatl ination and/or in	n occurred at the til vestigation, in my	me, date and place, as opinion, death occurre	nd due to the ca d at the time, da	use(s) and manner as s te and place, and due to	stated, to the cause(s)
To the within 2 To the complete	2	29b. Signature and title of certifier	Ymha		29c. Licens		29	d. Date signed (Month, August 28	
		30. Name and address of person who David R. Fowler				xaminer, 1	11 Penn	St, Balto.	<u>·</u>
Sta Registr		31. Date filed (Month, Day, Year) SEP 0 7	32. Redfistrar's Sig	gnature	Sell .				

		-	1 - State State Registrar	of Maryland / D	epartment of H Certificate of L		ental Hyg	iene _{g. No.} 2	2006	28259
			Decedent's Name (First, Middle, Last)				2. Date of Deat Month		Year	3. Time of Death
	Physicia /Medic		Benjamin H. M	oore			09	04	2006	0808vm
	Examin		4a. Facility Name (If not institution, give street and			Location of Death		4c. Cc	ounty of Death	
			Johns Hopkins Bayview			timore	2.5		O Dist	Land (Chata as Farrier
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birti	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year)	Cou	
	Director	-	246-54-1065 Usual Residence of Decedent	74			04/01/1	932	Nort	ch Carolina
	yland		10a, State 10b. County	10c. City, Town						10d. fnside City Limits
	e-f-el	Ş	Maryland	Bal	ltimore					1X☐Yes 2☐No
	or 28	Director	10e. Street and Number		10f. Zip Code		1	0g. Citize	n of What Cou	ntry?
	ath w	<u>a</u>	5520 Force Road		2120			U.S.		and ladica
	er de	Funeral	Armed	ecedent Ever in U.S. Forces?	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	Rican, etc.)	14.	Race - Ameri Black, White,	
5	irs aft	by	If Yes,	s 2∭ No Give r Dates:	1 ☐ Yes 2X No	Specify:		S	pecify: Bla	ick
ž	2 hou		15. Decedent's Education	16a.	Decedent's Usual Occup	ation	200	16b. Kind	of Business/Ir	ndustry
7	thin 7	Completed	(Specify only highest grade complete Elementary/Secondary (0-12) Colfeg	e (1-4or 5+)	(Give kind of work done of life. DO NOT use retired)			dens	
V	ygian ygian yr th	9	12		Supervisor				Corpora	ation
and	should be filed within 72 hours after death with the Maryland nd Mental Hygiane. marked other than "naturel", or lieme 23s or 28e-f ehow imatic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	Villiams		ітатө)	
2	d Men narke natic	ပ္	Mott C. Moore 19a. Informant's Name/Relationship (Type, Print)	10h	Mailing Address (Street				Town State 7	n Code)
<u> </u>	d 2 st th and 7 is r	r ii			20 Force Roa					
a)	1 an Heal tem 2 other	1	Loretta Moore / Wife 20a. Method of Disposition		Disposition (Name of y, crematory or other place		Date		tion - City or T	
ē	ages ent of nt: If I		1 Burial 2 Cremation 3 Removal fro 4 Donation 5 Other (Specify)	om State	oly Redeemei	02,02,	/ 2006	Balt	imore,	Maryland
ашшо	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. Importent: If Item 27 is marked other than "naturel", or Iteme 23a or 28e-1 ehow any Injury or other traumatic event, the Madical Examinat must be notified at once.		21. Stepature of Funeral Service Licensee	HOSCIN	22. Name and Addres		Derrick	. C.	Jones I	F/H, P.A.
ñ	Depa Impo any I		Muffe.	#	4611 Park H	Igts. Ave.	., Balti	more	, Mary	Land 21215
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the deeth. Do non each line.	not enter the mode of dyin	g, such as cardiac o	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician		fmmediate Cause (Final disease or condition	Beato HER to (or as a consequence of	NATION					Olisot and Death
	/Medical Examiner		resulting in death)	to (or as a consequence of	of):					
		er	Sequentially list conditions, and any, leading to immediate cause. Enter Underlying	BRAIN ED	EMA				4	
ī	betr i insit	min		issive left o	JERAN J. WA	M. PHECE	benemi		OKC	
ĵ.	cate be executed physicien and the burial-transit	Examin		to (or as a consequence of					0,-	
2/60	ite be iysicie iye bu	dicai	d.							
٥	certifica nding ph use as th	0	IF FEMALE:							
X Q Q	death ce e attendi ad for use	lan/l	23b. Was decedent pregnant 1 Lin	outcome of pregnancy ve birth 2 Fetal death		,		23	d. Date of delike Month	very Day Year
	w requires that the death certifi been signed by the atlending I should be detached for use as	Physician/M	1 Van 2 Na	egnant at time of death nknown	5 Other (specify)					
7	requires that the been signed by th hould be detache	H.	Part II. Other significant conditions contributing t	o death but not resulting in	the underlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
SD	uires sign id be	d by	HYPERTENSION PERIPHER	AL VASOULA	DISEASE		1 🗆 Y	es 2 🗆	No 3□Pro	babiy 4 Donknown
Vital Records,	law rec as beer 2 shou	Completed	ROWAL TRANSPLANT	-			24a. Was a	en	24b. Were aut	opsy findings available
e T	sician: The law certificate has t irector, page 2 s	E					autops perfor 1 Yes	med?	death?	opsy findings available ompfetion of cause of
II	lan: rtifica	BeC	25. Was case referred to medical examiner?			26. Pface of Deatl				
	<u>></u> . <u>s</u> o	To	1 ☐ Yes 2 ☑ No Hospital:	☑ Inpatient 2 ☐ ER/Ou	tpatient 3 DOA Oth	4 Nursing no				ify)
Ē	ding Ph h. After th funeral	ë ë	1 Natural 5 Pending (A		Time of 28c. Injur		28d. Describe h	ow injury	occurred	
<u>s</u>	ten teat tor:	cat	2 Accident investigation 3 Suicide 6 Could not be	lace of Injury - At home, fa		Yes 2 □No	28f Location /S	treet and	Number of Ru	ral Route Number,
DIVISION OF	or Attenester deat Director:	Certification:	determined 200.	uilding, etc. (Specify)	mi, sileet, factory, onice		City or Tow		rambor or ria	arriodio vernoor,
	To the Hospital or At within 24 hours effer d To the Funeral Direct complately filled in by		29a. Certifier 1 Certifying Physician: To	the best of my knowledge	a, death occurred at the tir	ne, date and place,	and due to the c	ause(s) a	nd manner as	stated.
	he Ho in 24 I he Fu plately	Medical	(Check only 2 Medical Examiner: On the	ne basis of examination an nanner stated.	d/or investigation, in my o	pinion, death occur	red at the time, o	late and p	lace, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	MARC MA	29c. Licens		4		signed (Month	
	,/	: 5	- Laceton Control of	,	' KE	2000		09/	06/20	or 6
	b		30. Name and address of person who completed of D MUTHNCLOTINDAN, 46			BALTIN	NORE. NA	ARU	LAND	21224
	Sta	ate	31. Date filed (Month, Day, Year) 3	2. Registrar's Signature			- 1 14			
4	Regist		SFP 0 7 2006	Delva &	books					
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State of Maryland / Department of Health and Mental Hygiene? \cap \cap \subset

			For State Registrar	State of Mary		artment of H			ene2006	28260
	Physici		1. Decedent's Name (First, Middle,	Last)	mar	ray		2. Date of Death	Day Year 5, 2006	3. Time of Death 9.48 A M
	/Medic Examin		4a. Facility Name (If not institution, 5303	Sipple +	Ine	4b. City, Town, or	Location of Death	re	4c. County of Death	
	Funeral Director		5. Social Security Number 248-74 6707 Usual Residence of Decedent	S. Sex 7. Age (In 1	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		lace (State or Foreign try)
	e Maryland Be-f show	ctor	10a. State 10b. County	NIA 10	c. City, Town or Lo	Salt	tima	w		0d. Inside City Limits 1 Yes 2 □ No
	ours after death with the Maryland ral', or Itema 23e or 28e-f show Exacting the rediffed at	Funeral Director	10e. Street and Number 5363 11. Marital Status	ple Ave	r in U.S. 13.	10f. Zip Code 2 Was Decedent of H	206 lispanic Origin? (Spe		g. Citizen of What Coun	an Indian,
020	hours after d ural', or Item	þ	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces?	1	If Yes, specify Cuba 1 ☐ Yes 2/25No	lispanic Origin? (Spi an, Mexican, Puerto Specify:	Rican, etc.)	Black, White,	etc. Plack
J-0171	within 72 he ene. then netu	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		(Give	DO NOT use retired	during most of work	ing	8b. Kind of Business/Inc	- 1
/lang z	uld be filed Mental Hygi irked other itic event, I	To Be Co	17. Father's Name (First, Middle, L.	ast)		8	18. Mother's Name	Jel	Reison	1
e, mar)	1 and 2 sho Health and P em 27 la ma ther trauma		19a. Informant's Name/Relationshi Lindia E. Dow. 20a. Method of Disposition	- daughter		3 Sipple	Are. P.	salto.	City or Town, State, Zip	6
altimor	mit. Pages vartment of Hortent: If ite injury or of		1 Burial 2 Cremation 3 4 Donation 5 Other (Sp.	3 □Removal from State	remetery, crei	2. Name and Addre	9-9.	-06 L	ansdown Rlin st	1
ñ	Per Imp Per eny		23a. Part1. Enter the disease, or o shock, or heart fellure. List o	omplications that ceused the niy one cause on each line.	ele n	ancym	waller	e Renemor respiratory arres	I Service	Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		Immediate Cause (F V at disease or condition resulting in death)	a. Due to (or as a co	ons quence of):	ING h	CArt	TA .	lure	Years
V	xecuted and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due i was o		c (rea	e Renly	14 6177	N.T	7 = 177 9
8/00,	be egician ician buria	dicai	resulting in death) Last	Dui ti (or as a o	naequence III	B He	mile	OIA	0)	ign
O. Box 6	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	,	<i>J' ''</i>	23d. Date of delive Month	ory Day Year
rds, r	n requires that the deben signed by the should be detached		Part II. Other significant condition	s contributing to death but n	ot resulting in the u	nderlying cause giv	ren in Part I.	23e. Did toba	acco use contribute to the	
II Kecords,		Completed	(on	A/C H	reru	4/4/)	IWN	24a. Was an autopsy perform 1 Yes 2	24b. Were auto prior to con death? No 1 \(\subseteq Yes	psy findings available inpletion of cause of 213 No
of Vital	Physician: The lav this certificate has ral director, page 2	To Be	25. Was case referre medical examiner? 1 Yes 2 No 27. Manner of Deat	Hospital: 1 ☐ Inpatient	2 ER/Outpaties	III 3 DOA	ner: 4 🗆 Nursing Ho	h (Check only one ome K Resider 28d. Desche hov	nce 6 Other (Specif	y)
DIVISION OF	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director.	Certification:	1 Natural 5 Pending 2 Accident investige 3 Suicide 6 Could not determine	ation of be	- At home, farm, st	M 1 🗆	rk? Yes 2 □ No	28f. Location (Str. City or Town,	eet and Number or Rura State)	I Route Number,
2	Hospital of 24 hours all Funeral Detely filled i	edical Ce		Physician: To the best of m xaminer: On the basis of exa and manner stated	amination and/or in					
	To the within To the Comple	Me	29b. Signature and alle ovcertifier	MA.A.	ma	29c. Licens	se number	29	d. Date signed (Month,	Day, Year)
	3		30. Name and address of berson v	vho completed cause of death	419 WK	Print) PEDWOO	DST.	BALTIM	ORE, MD 2	1201
	Sta	ate	31. Date filed (Month, Day, Year)	7 2006 32. Registrar's	Signature	Specific 1		,		

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			1 - State of Maryla State of Maryla State	and / Depa <i>Cer</i>	artment of Health tificate of Deat		giene 20 (06 28261	
	Physicia	an	Decedent's Name (First, Middle, Last)			2. Date of Dea Month	Day V-	3. Time of Death	
	/Medic	ai	Joan R. 4a. Facility Name (If not institution, give street and number)	Messineo	4b. City, Town, or Location	Septemb	4c. County of D		
	Examin	er	Stella Maris Hospice		Timonium		Balti		
	Funeral Director		5. Social Security Number 213-30-4170 6. Sex 1 ☐ M 2 1 X F 7. Age (In y	73 Yrs.	If Under 1 Year If Und Months Days Hour	der 24 Hrs. s Min. 8. Date of Birt (Month, Da)	Day, Year) Country)_		
	land ow		Usuel Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	cation			10d. Inside City Limits	
	Mary a-f sh	tor	Maryland Baltimore	Baltimo	re			1 ☐ Yes 2 XX No	
	or 28	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of Wha	•	
	eeth v	Funeral	60 Whips Lane, Unit 30 11. Marital Status 12. Was Decedent Ever in the control of the control	n U.S. 13. \	21236 Was Decedent of Hispanic	Origin? (Specify Yes or No-	U.S.	A. American Indian,	
336	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hyglene. If Item 27 is marked other then "netural", or Items 23a or 28a-f show or other traumatic event, the Medical Exercises must be inclined at	6	Armed Forces? 1 N Never Married 2 Married 3 Widowed 4 Divorced Armed Forces? 1 Yes 2 N No If Yes, Give Year or Dates:	'	f Yes, specify Cuban, Mexi 1 □ Yes 2 □ X No <i>Spec</i>	can, Puerto Hican, etc.)	Specify:	White, etc.	
20	72 hou	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	ient's Usual Occupation kind of work done during n	nost of working	16b. Kind of Busine	ess/Industry	
21215-0036	within ene. then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. I	no NOT use retired)		Sun Pape	r	
	2 should be filed withir and Mental Hygiene. is marked other then aumatic event, the Ma	0	12 17. Father's Name (First, Middle, Last)			other's Name (First, Middle,			
ılan	should be tand Mental Is marked o	To B	Andrew Messineo			Elizabet	th Kea	rney	
Maryland	2 sho		19a. Informant's Name/Relationship (Type, Print)		•	mber or Rural Route Numbe			
	1 and Health em 27		Sr. Anne Hefner COusin 20a. Method of Disposition 20	h Place of Disno	eroba Court sition (Name of	Baltimore,	20c. Location - City		
Jou	Peges ent of nt: If It ry or o		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Most Holl	er Cemetery	9-7-2006	Baltimore	Maryland	
Baltimore,	permit. Peges 1 and 2 Department of Health s Importent: If Item 27 is any Injury or other tra once.		21. Signifure of heral Service Licensee	22		acilityRuck Towsor	n Funeral		
			23a. Part1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line.					Approximate Intervat Between	
	Physician		Immediate Cause (Final disease or condition CEREBROVA	SCULAR A	CCIDENT			Onset and Death	
	/Medical Examiner		resulting in death) Due to (or as a con	sequence of):					
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8760,	icate be executed physicien and s the burial-transit	i Ex	resulting in death) Last Due to (or as a con	isequence of):					
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ords	w requires that been signed b should be deta	ted b				10'	Yes 2□No 3□	Probably 4 X Unknown	
Division of Vital Records,	e law I hes by	Completed				24a. Was autor perio 1 Yes	osy prior ormed? deat	e autopsy findings available to completion of cause of th? Yes 2□ No	
/ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:		Other	tace of Death Check only o			
of	Phys this ral dii	2	1 ☐ Yes 2 📉 No	2 ER/Outpatier 28b. Time o	IL SELDON 4E	Nursing Home 5 Resident	dence 6X1Other (how injury occurred	Specify) HOSPICE	
on	nding F nth. r: After e funera	ation	1 X Natural 5 □ Pending (Month, Day Yea 2 □ Accident investigation	(r) Injury	Work? M 1 ☐ Yes 2	i			
Divis	tal or Attendi s after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (Sp.	At home, farm, str pecify)	reet, factory, office	28f. Location (City or To		or Rural Route Number,	
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	edicai C	29a. Certifier (Check only one) **Certifying Physicien: To the best of my one) **Certifying Physicien: To the best of my one one of the best of my one one of the best of my one of the best of the best of my one of the best of						
	To th To th	Ž	29b. Signature and title of cartifier		29c. License numb	per	29d. Date signed (A	Month, Day, Year)	
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_	10		DR. TARIQ MAHMOOD 2300 DUL	ANEY VAL		ONIUM, MD 210	093		
	Sta Regist	ate rar	31. Date filed (Month; Day, Year) SFP 0 7 2006 32. Registrar's S	Signature	look !				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** September 5, 2006 3:30 MICHAEL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 302 E. Joppa Road, #1504 Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | May 20, 1970 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 216-02-1357 1 X M 2 □ F 36 Marvland Director Yrs. Usual Residence of Decedent death with the Maryland init. Pages 1 and 2 should be filed within 72 hours after death with the Marylan rartment of Heatth and Mental Hygiene.

ortant: If item 27 is marked other than "natural", or Itama 23a or 28a-1 ehow Injury or other traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Towson Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 302 E. Joppa Road #1504 21286 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ð Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Never employed Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) J. Maccini Louis Carol Monterisi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis J. Maccini-father 5819 Meadowood Rd., Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Serv. Corp 9/11/06 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) graft versus host disease **Physician** 700-15 /Medical Due to (or as a consequence of) Examiner rone allogeneic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physicien and burial-transit myelogen ors Chronic lechemia Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ō 4☐Pregnant at time of death Month Day 5 Other (specify) signed by the a 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funaral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) Rd #325 Luthenille MD 21093 Falls 10753 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001 32 Registrar's Sign

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physician and the burial-transit Hospital or Attending Physician: Tha law raquiras that the daath certificata ba axacutad Box 68760. attanding ph d for use as the signad by the a P.O. Records. baen sig certificata has b iractor, page 2 sl Division of Vital this After s after da. fillad in by

2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** September 5, 2006 JUNE LORRAINE Mackeever 5:40 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Morningside House of Laurel Laurel Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 1 ☐ M 2 🖳 F 579-20-7033 81 27, 1925 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Charlotte 1. Yes 2 No Funeral Director Florida Punta Gorda 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3941 LaCosta Island Court 33950 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married ☐Yes 2XXo filad within 72 hours afti Hygiana. Maryland 21215-0036 Pagas 1 and 2 should ba filad within 72 hours aftinant of Haalth and Mantal Hygiana.
ant: If Item 27 is marked other than "natural", or inry or other traumatic event, Ite Mcdical Examilary or other traumatic event, Ite Mcdical Examilary. 1 Yes 2 TNo þ If Yes, Give Year or Dates: Specify: 3 XXVidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary University of Maryland Grade 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William F. Deffer Margaret L. Brooke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) parmit. Pagas 1 and 2 s
Dapartment of Haalth an
important: If Item 27 is
any injury or other trau Robert K. Ohm 9317 Player Drive Laurel, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 9/7/2006 Odenton, Maryland 21. Signature of Funeral Septic, Licensee 22 Name and Address of Facility Donaldson Funeral Home, P.A. ∠ M00160 aure Nanday 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Alzheimer's Disease yrs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami Due to (or as a consequence ot): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Malignant Melanoma 3 Probably 4 Unknown 1 ☐ Yes 2 XXVo Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes

2€€No 24a. Was an autopsy performed? Yes XXNo 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Assisted Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Living ٩ 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funaral C complately fillad i 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 43575 September 6, 2006 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Angela Duncan, M.D. 7350 Van Dusen Road #130 Laurel, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

			For State Registrar	State of Maryland		rtment of H tificate of L		Reg	2006	28264
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last Chester E. Mian					2. Date of Death Aug 31,	2006 Year	3. Time of Death 18:48P M
	Examin		4a. Facility Name (If not institution, give Southern Maryla			4b. City, Town, or Clin		ר	4c. County of Dea Prince G	
Ź	Funeral Director		5. Social Security Number 6. Se		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Jan 14,	9. Bir 1920 G1e	hplace (State or Foreign number) n Lion, Pa
	anyland ahow	'n	Usual Residence of Decedent 10a. State 10b. County		, Town or Lo	cation Heights				10d. Inside City Limits 1 ☐ Yes X X No
	with the M a or 28a-f	Directo	Maryland Prince Go 10e. Street and Number 7210 Lansdale			10f. Zip Code 20747		100	g. Citizen of What Co United St	ountry?
36	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-1 ahow any figury or other traumatic avent, the Medical Exercises must be notified at another.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Amed Forces? 1 ∰ yes 2 □ No 1941 If Yes, Give Year or Dates: 1945	_	Vas Decedent of Hi i Yes, specify Cubai ☐ Yes 2XXIVo	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
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, Mary	and 2 shouelth and No. 27 is maintransactions.		19a. Informant's Name/Relationship (7) Yolanda Miara (Wi		19b. Mailin 7210	g Address (Street a Lansdale	nd Number or Rue Street	ral Route Number, C District	City or Town, State, A. Heights,	Zip Code) MD 20747
more	Peges 1 and nent of He and: If Item ury or oth		20a. Method of Disposition 1 ∰ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	metery, cran	sition (Name of natory or other place tion Ceme	etery Se		Clinton,	
Balt	permit. Depertr Importa		21. Signature of Funeral Service Licens	pres MO/	45 / A1	exandria.	Ferry Ro	oad, Clint		6633 01d 0735
	Physician		23a. Part1. Enter the disease, or condo shock, or heart failure. List only o Immediate Cause (Final disease or condition	cations that caused the death, ne cause on each line.		ar the mode of dying	g, such as cardiad	or respiratory arres	t,	Approximate Interval Between Onset and Death
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ō	Attanding Physician: r death. actor: After this certifics by the funeral director, p	: To	1 ☐ Yes 2 ☑ No 27. Manger of Death	28a. Date of Injury	R/Outpatien 28b. Time of	28c. Injury Work	4 Nuising n	ome 5 Residen	ce 6 Other (Spe	cify)
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	To tha Hospital or At within 24 hours after or To tha Funeral Dirac completely filled in by	edicai	29a. Certifier (Check only one) 1. Certifying Phy 2 Medical 5 xami	sician: To the best of my knowner: On the basis of examinati and manner stated.	vledge, death on and/or inv	occurred at the tim restigation, in my op	e, date and place pinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
	Tot Tot	W	29b. Signature and title of confider	u mi)		29c. License			1. Date signed (Mont	
	1541		30. Name and address of person who co				2 late in	1 1 20	<i>U</i>	
	Sta Registr		31. Date filed (Month, Dey, Year)	328 Southern ave 32. Registrar's Signate	ure SE	Suite SIL	washin	gun be to	USZ.	
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State of Maryland / Department of Health and Mental Hygiene 0 0 6 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 37 M Physician 9UGUST WARREN WILLIAM MARQUARDT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Doctor's Community Hospital Lanham 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1∭M 2□F Yrs Minnesota Director 475-30-6626 11-01-1930 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Directo Maryland Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "naturel", or Items 23a or the Medical Examiner must be U.S.A. 713 Band Shell Street 21771 Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 ∑ Yes 2 □ No 1951—
If Yes, Give
Year or Dates: 1955 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Teacher/Research 5+ State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 Ie marked oth eny linjury or other traumatic event <u>anne</u>. Frieda Neubert William Marquardt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Marquardt - Wife 713 Band Shell Street, Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 9/2/2006 Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Liberts of 4739 Baltimore Ave., Hyattsville, MD 20781 23a'. Part 1. Enter the disease, or complication of at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYELODYSPLASTIC Physician SYNDROME YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PULMONARY DISEASE - OBSTRUCTIVE 1 Yes 2 No 3 Probably 4 Dunknown Completed RIGHT LOWER LOBE PNEUMONIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed ANEMIA 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: A 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) a 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) D16897 Name and address of person who completed cause of death (Item 23a) (Type, Print)
NEW CARROLLTON, MD., 20784 WILLIAM D, ROSSON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

MARQUARUT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per fb 8859 9-13-06 vt State of Maryland / Department of Health and Mental Hygiene 0 0 6

28266 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Madeline L. Mamolita 8:30 P. M August 31 2006 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ellicott City Health & Rehab. Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 22, 1 9. Birthplace (State or Foreign 6 Sex **Funeral** Hours 217 09 1186 1 ☐ M 2 🛛 F Yrs. Maryland 85 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event. It a Medical Examinat must be notified at Maryland 1 Yes 2 XNo Howard Ellicott City Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with U.S. 3000 North Ridge Road 21043 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene. 1 Never Married 2K Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Packer Moores Candy 6th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sophie Shoebring To Andrew Doelle 19a. Informant's Name/Relationship (Type, Print) 191. Mailing Address (Street and Number of Bural Route-Number, City of Town, State, Zin Code 21113 permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any Injury or other traum once. Joseph Mamolita / Husband 159 Rockland Drive Camden Wyoming, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, Maryland Meadowridge Mem. Park 9/5/2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign and e of Juneral Service I 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the inc. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** P7457 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, 🖔 Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 Ø No 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ P 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed 2 1 No 2 No 1 Yes To the Hospital or Attending Physician: ieral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Jursing Home ů 5 Residence 6 Other (Specify) 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 12 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) determined after 4 Momicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28575 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RE HEICHTS AVE, AINEEM 7220 32. Registrar's Signature 31. Date liled (Month, Day, Year) State 2005 Registrar

			For	State of Maryla		ent of Health and ate of Death	Mental Hygi	^{ene} 2006	28267
a	F. 3	*	Registrar 1. Decedent's Name (First, Middle,	Last)	Certifica	ale of Dealif	2. Date of Death	J. No.	3. Time of Death
	Physici /Medi		Jerry	McCoy			September	e 4, 2006	655 pm
	Examir	ner	4a. Facility Name (If not institution,	give street and number)	40 D	ily, Town, or Location of De	ath Ly	4c. County of Death	
	Funeral Director		216.62.4981	5. Sex 7. Age (in yrs	s. last birthday) If Un Yrs. Month	der 1 Year If Under 24 H hs Days Hours Mi		(ear) 9. Birthp Cour 1960 M	lace (State or Foreign itry)
	/land low		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Location			1	0d. Inside City Limits
	within 72 hours after death with the Maryland ene. than "naturel", or items 23a or 28a-f show ha Medical Examinar must be multified a	Funeral Director	mD Balt 10e. Street and Number	imore w	oodstock	Zip Code	10	g. Citizen of What Cour	1 ☐ Yes 2 Two
	ath with	raiD		nmon tree c		21163		USA	
10	ours after dea rei', or items Evanthame	Fune	11. Marital Status 1 ✓ Never Married 2 ✓ Marrie	12. Was Decedent Ever in Armed Forces? d 1 Tyes 2 No		cedent of Hispanic Origin? specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White,	etc.
036	ours aft	b	3 Widowed 4 Divorced	If Yes, Give 7 Year or Dates:	1 🗆 Yes	s 2 No Specify:		Specify: Blo	
∫ 215-0036	in 72 hour n "naturel"	Completed	15. Decedent's (Specify only highest	grade completed)	16a. Decedent's U (Give kind of life. DO NO	Isual Occupation work done during most of v Tuse retired)		6b. Kind of Business/In-	dustry
212	77 75 10	Com	Elementary/Secondary (0-12)	3 years	Program		- 3	Ohn Hopkins	s Hespital
$\mathcal{HC}_{\mathcal{O}}$	ould be filed Mental Hygi arked other atic event, I	Be	17. Father's Name (First, Middle, La		9	18. Mother's N	lame (First, Middle, M	aiden Sumame)	•
arvie	shou nd M	10	19a. Informant's Name/Relationshi	COL p (Type, rint)	19b. Mailing Addr	ess (Street and Number or	- 4	City or Town, State, Zip	Code)
S. C.	1 and 2 Health a tem 27 is		Rosa mccoy	mother	3/04 Pe	The state of the s		oc. Location - City or To	
13.0	90=5		20a. Method of Disposition 1 Durial 2 Cremation 3 4 Donation 5 Other (Spe	3 □Removal from State	cemetery, crematory	or other place)	8.1/2 D		
Jew	permit. Pag Department Important: eny injury o		21. Signature of Funeral Service Li				raughn ca	veere fune	
<u> </u>	Depa Impo eny ii		Yangha C	· Clans	8729			own mo	
			23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final	omplications that caused the de nty one cause on each line.	ath. Do not enter the n	node of dying, such as card	lac or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conse	equence of);				
	Examiner	_	Sequentially list conditions,	b. End SA	age Ken	al Disea	SL		
J	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Diabeles	melli	tus			
00	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a conse	equence of);				
58760,	the ty	edica		d					
Box 68	leath certific attending pl	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg 1□Live birth 2□Fe		c pregnancy		23d. Date of delive	•
O. BI	he deal the att	ystcia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown				Month	Day Year
P.O.	Physicien: The law requires that the death certificate the certificate has been signed by the attending properties of control of the certificate has been signed by the attending properties.	by Ph	Part II. Other significant condition	s contributing to death but not re	esulting in the underlyin	ng cause given in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?
of Vital Records,	w require been sig should b	ted t					-	s 2 □No 3 □ Prob	
Bec	he law a has b ge 2 si	Completed					24a. Was an autopsy perform	ed? death?	psy findings available mpletion of cause of
ta_	ysicien: The l is certificate ha director, page	Be Co	25. Was case referred to medical			26. Place of D	1 Yes 2		2 No
of <	Physic this ce al direc	2	examiner? 1 Yes 2 No				g Home 5 Resider	ice 6 Other (Specif	y)
	nding I tth. : After e funer	ation	27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investiga		Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	20d. Describe nov	Vinjury occurred	
Division	or Attendi after death. Director: A	Certification:	3 Suicide 6 Could no 4 Homicide determin		home, farm, street, fac cify)	ctory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
	To the Hospital or Attending within 24 hours after death. To the Euneral Director: After completely filled in by the fune.	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of my k xaminer: On the basis of exami	nowledge, death occur nation and/or investigat	red at the time, date and plation, in my opinion, death of	ace, and due to the car courred at the time, dat	use(s) and manner as s te and place, and due to	tated. o the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	0 10		29c. License number	29	d. Date signed (Month,	Day, Year)
	/) Ame	J. All	0.0	84566		114/06	
	5		30. Name and address of person w	no completed cause of death (It	em 23a) (Type, Print) WRU //	and Grene	ral Hosp	ortal	
		ate	31. Date filed (Mon S. Pas. Year)	2006 32. Projistrar's Sig	nature St. Snaw				
	Regist	ावा ।		Modern	S. GOSO				

DHMH 17 Rev 1/2001

ORIGINAL

1 _ For

		•	1 - For State Registrar			Cert	ificate of	Death		Reg. No.	2006	28268
	Physici	an	1. Decedent's Name (First, Middle, Las		-110	,			2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	street and number)) E/C 5		4h City Town o	r Location of Dea	Augus	7	2006,	1 - 4 111
	Examin	ier	HARBOR	/405P151	96			MURE,			N/A	
	Funeral Director		225 30 7951	C 14 0 W F	(In yrs. last bii 30	thday)_ Yrs.	Months Days	If Under 24 Hrs Hours Min		th 19, Year) 2, 19	9. Birthp Cour	olace (State or Foreign oliny) irginia
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loc	ation				1	0d. Inside City Limits
	Mary	to	Maryland N/A		Balt	timo	re					1 X Yes 2 ☐ No
	death with the Maryland rms 23a or 28e-f show r man be mulling at	ai Directo	10e. Street and Number 1345 Cambria S	treet			10f. Zip Code 21:	225			en of What Cour J.S.	ntry?
020		by Funerai	11. Marital Status 1 Never Married 2 A Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ver in U.S.	11	as Decedent of H Yes, specify Cubin Yes 2K No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No to Rican, etc.)		4. Race - Americ Black, White, Specify: Whi	etc.
0-017	filed within 72 hours after Hygiene. other then "neturel", or Ite ent, the Medical Exertine	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+ 2 years		a. Decedent's Usual Occupation (Give kind of work done during most of work ife. DO NOT use retired) Beautician			orking		air	dustry
משמת	ild be filed lental Hygi ked other ic event, I	To Be Co	17. Father's Name (First, Middle, Last) Willi	am M. Robi	nson				me (First, Middle hie L. B		Sumame)	
, mary	and 2 shoulelth and M 27 is mar er traumat	_	19a. Informant's Name/Relationship (Гуре, Print) SOП		_	Address (Street		oural Route Numb sterstow			
umore	int. Pages 1 and ment of He ortent: if item injury or others.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemete	ry, cremi Have		ark 9/2		Glen		, Maryland
Dall	permit. Pages Department of Importent: If it any injury or once.		21. Signature / Luneral Sarvice Licen	S 00					Gonce Fu way Bal			e, P.A. land 21225
T			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	blications that caused tone cause on each line	he death. Do	not ente	r the mode of dyin	ng, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. CANCIN Due to (or as a b. BNAIN Due to (or as a	consequence	of): PAS:	1845 - s	fo che	MOTHENA	pyla	CALATON	6 MONT &
09/00,	intificate be executed ing physicien and as the burial-transit	Medical Examine	cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last	c. HYPOTEN Due to (or as a	consequence	ANG of):	DEH.	YDNATI			0	2-3 WKs.
C. Box d	death certif e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death		Ectopic pregnanc Other (specify)	y		2	3d. Date of deliving Month	ery Day Year
L	s that gned b		Part II. Other significant conditions of		not resulting	in the un	derlying cause gr	en in Part I.	23e. Did	tobacco u	se contribute to t	he cause of death?
ecords,	equire sen sig tould b	ted	ATRIAL CIBRI	LCATION					1 🗆	Yes 2	,	pably 4 □Unknown
r	The lay ate hes page 2	Completed by	HISTORY OF U	ICIN MESE	TANT	ENT	EURCOC	c1.	24a. Was auto perf 1 🗆 Yes		24b. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of 2 No
<u> </u>	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Ott		eath (Check only			
ō	Jing Physicism: After this certific funeral director.	. To	1 ☐ Yes 2 ⊠(No 27. Manner of Death	28a. Date of Injury (Month, Day	t 2 ER/O	Time of	28c. Inju		Home 5 ☐ Res 28d. Describe			ν)
<u>0</u>	anding ath. pr: Afte	atio	1	1	rear)	Injury		Yes 2 □No				
DIVISION	e Hospitel or Atten 24 hours after deat e Funaral Director: letely filled in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injui building, etc.	y - At home, f (Specify)	arm, stre	et, lactory, office		28f. Location City or To	(Street and wn, State)	d Number or Run	al Route Number,
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funarel Director: After this certifical completely filled in by the funeral director.	edicai	(Check only 2 Medical Examone)	ysician: To the best of niner: On the basis of a nd manner stat	examination and	nd/or inve	estigation, in my	pinion, death occ	curred at the time	date and	place, and due t	o the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier	re, Ma	o .		29c. Licens	e number		AUG.	e signed (Month, ロムタア るの	Day, Year)
	10		30. Name and address of person who 31. Date filed (Month, Day, Year)	completed cause of de	ath (Item 23a)	(Type, F	rint) HAN	BOR	140510	TAL		
	Sta Registi		31. Date filed (Month, Day, Year) SEP 0 7 2	006 32. Registral	's Signature	Jan.	sele!					

			For State Registrar	State of M	laryland	d / Depa <i>Cei</i>	artment of F	lealth and <mark>I</mark> Death	Mental Hy	gienę2 (Reg. No.	106	28269
			1. Decedent's Name (First, Middle,	Last)					2. Date of De	aath		3. Time of Death
	Physici		Rose Marie	Nickles					AUOUS7	- Bay	2006	Z:30PM
	/Medic Examin	_	4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	r Location of Death	1		ty of Death	
1			Doctor's Commun	ity Hospita	1		Lanham			Pri	nce G	eorge's
	Funeral		, , , , , , , , , , , , , , , , , , , ,		ge (In yrs. la	ast birthday)	If Under 1 Year Months Days	Il Under 24 Hrs. Hours Min.	8. Date of Bi	rth av. Year)	9. Birth	place (State or Foreign
	Director		215-82-2975	1□M 2X)F	91	Yrs.			Nov. 1			Virginia
	pu ,	1	Usual Residence of Decedent 10a. State 10b. County		10c City	. Town or Lo	cation					10d. Inside City Limits
	eho eho	5	,	C ! -								11 Yas 2 □ No
	he N 188a-1	ect	Maryland Prince	George's	нуат	tsvil]	10f, Zip Code			10g. Citizen o	4 M/ban Carr	21
	with t	吉		A			20781			U.S.A.	I What Cou	nu y :
	s 23	eral	4707 Baltimore	12. Was Deceden	t Ever in III	S 12		lienanic Origin? (S	necify Ves or N		ace - Ameri	can Indian
21215-0036	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f ehow other traumatic event, it a Medical Examinar must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Marrie 3 🕅 Widowed 4 ☐ Divorced	Armed Forces	?]No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2🌠 No	Specify:	o Rican, etc.)	Spec	ack, White,	
Ō	72 ho	Completed	15. Decadent's			16a. Dece	dent's Usual Occup	ation	kına	16b. Kind of	Business/In	dustry
215	hin 7	ple	(Specify only highest Elementary/Secondary (0-12)	College (1-4o	5+)	life.	kind of work done DO NOT use retired	1)	xmy			
21	filed within Hygiene. other than	Con	8			Homema	aker			Own H		
pu	be file d oth	Be	17. Father's Name (First, Middle, L	ast)				18. Mother's Nan	,	, Maiden Sumi	ame)	
yla	should but and Ment	ဥ	John Rehack					Tereza	Szustik			
Maryland	2 sh and fs m		19a. Informant's Name/Relationsh				ng Address (Street					
	and lealth m 27		Nick Nickles -	Son	20h Bi		Queen An	ne Circle	e, Anna Date	20c. Location		
Baltimore,	Pages 1 Tent of 1- Int: if ite Iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from Stat	9 06	emetery, crei	natory or other plac	· I				
ţ	t Pa tant dury		4 Donation 5 Other (Sp		For		oln Ceme					
Bal	permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than 'any injury or other traumatic event, IL a Magnee.		21. Signature of Funeral Service L	cenge		22	Name and Addre					MD 20781
	20204	0 0	23a. Part 1. Enter the disease, or o	complications that cause	ad the death	Do not ent					rire,	Approximate
			shock, or heart failure. List of	only one cause on each	line.	^				111031,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	cule		enal	railu	re			Days.
	Examiner			Due to (or a	s a consequ	ience of):						
в		-d	Sequentially list conditions, if any, leading to immediate	b. — Due to (or a	s a consequ	ience of):					+	
1	nsit	듣	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
· .	icate be executed physicien and s the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or a	s a consequ	ience of):			-			
8760,	e be /sicie	dlcal		d								
9	Attending Physician: The law requires thet the death certificate be executed rideath. sctor: Atter this certificate hes been signed by the ettending physicien and by the tuneral director, page 2 should be detached for use as the burial-transit.	edic										
Box	n cert andin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Tetorio programa			23d. [Date of deliv	ery
	death e ette	icla	in the past 12 months? 1 □ Yes 2 ☑ No	4 Pregnant			Ectopic pregnancy Other (specify) _	/		,	Month	Day Year
P.O.	requires thet the death certific been signed by the ettending p should be detached for use as	Completed by Physician/Me	9 Unknown	9□ Unknown								
	gned ge de	Dy P	Part II. Other significant condition			•	nderlying cause giv	ven in Part I.	23e. Did	tobacco use co		he cause of death?
g	en sig	ed	Sepsis 10	seast c	auce	8	Pleura	+ effusio	10	Yes 2 □ No	3 🗌 Prol	bably 4 Unknown
Records,	awre ss be 2 sho	plet	Congestive	Heart 1	ailun	. 1	11/201 S	leuosa	24a. Was		. Were auto	opsy lindings available
Ä	The ste he	E		J					perf	ormed? 2 2 No	death?	
ita	ian: artifica	Be	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only	one)		
>	hysio nis ce I dire	To	1 ☐ Yes 2 No	Hospital: 1 Inpa	tient 2 🗆 I	ER/Outpatier	nt 3□ DOA Oth	^{ner:} 4 ☐ Nursing H	lome 5□Res	idence 6 🗆 C	ther (Speci	fy)
0	ng Pi fter ti inera	:io	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, E	jury ay Year)	28b. Time o Injury	Wor		28d. Describe	how injury occ	urred	
Sio	eath. or: A	cat	2 Accident investig	ation				Yes 2 □ No				
Division of Vital	frer d frect n by	Certification:	4 Homicide determine	ned 289. Place of I	njury - At ho etc. <i>(Specif</i> y	me, lam, str	eet, lactory, office			(Street and Nui wn, State)	nber or Rur	al Route Number,
	urs a		20a Consider del as as a	Dhusis' T	A =4 ::= 1	ulade: 1 "			and direct in			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Atter this certificate hes i completely filled in by the funeral director, page 2	Medical	29a. Certifier X Cartifying (Check only 2 Madical E	Physician: To the best examinar: On the basis and manner	of examinat	wiedge, deat tion and/or in	n occurred at the till vestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time	cause(s) and a date and place	manner as s e, and due t	stated. o the cause(s)
	ithin ithe	Me	29b. Signature and title of certifier	and mamor	-		29c. Licens	se number		29d. Date sign	ned (Month,	Day, Year)
	E 48 4		▶ Nona	2 M.D			DY	8213		09-	01-	2006
			30. Name and address of person v	who completed cause of	death (Item	23a) (Tyne		8213 knd0		- 1	2 6	
5			reelaw A	shai 4	410	741		kndu	versti	15 M	0 20	0784
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	ture						
	Regist	ar	CED ()	7 2008	20	K	South ?					
DH	IMH 17 Rev 1/2	001	OLIV	· Louis	The state of the s	20						

ROSE MARIE NICKIES

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 4, 2006 SEPTEMBER **Physician** JA OH KIL 11:25P M /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner 4a. Sail Nate (If of institution, give street and number) Center Towson Baltimore Hours Min. 8. Date of Birth (Month, Day, Year) 02-23-1939 If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M XXF 67 KOREA Director 219-31-9011 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City. Town or Location "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at BALTIMORE **PERRY** HALL 1 ☐ Yes ¾ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ONE DALLINGTON COURT 21028 KOREA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X 1 No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc hours after 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify. KOREAN Baltimore, Maryland 21215-0036 þ XX Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Importent: if item 27 le marked other than eny injury or other traumatic event, the Me Elementary/Secondary (0-12) 12 YEARS College (1-4or 5+) OWN HOME HOUSEWIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (UNKNOWN) 0K HAN ္က 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) YEONG OH (SON) ONE DALLINGTON COURT, PERRY HALL, MARYLAND, 21028 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XX Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP | 09-09-2006 TOWSON, MARYLAND, 21204 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 1050 YORK 21. Signature of Funeral Service Licensee R. J. R. RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 (R. G.RUTH) Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC OVARIAN CANCER **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Oue to for as a consequence off ending physicien and you use as the burial-transit requires that the death certificete be executed Due to (or as a consequence of) been signed by the attending physicien should be detached for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes ANEMIA Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes No CEREBRIVASCULAR ACCIDENT s certificate has b 1 Yes 2 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 1 ☐ Yes 2 No 1 / Inpatient 2 ER/Outpatient ဥ 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death

1 Natural
2 Accident ate of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending М 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0 D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOON P LIM, M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, 'Day," Year) 32. Registrar's Signature State Registrar 7 2006 SFP 0

	1	State of Maryland / Department	artment of Health and M rtificate of Death	lental Hygien	711116	28271
Physicia		1. Decedent's Name (First, Middle, Last)		2. Date of Death Aug 31, 20	ax Year	3. Time of Death
/Medic	al .	Edward Calvin Pace	4b. City, Town, or Location of Death		c. County of Death	18:47 PM
Examin	er	la. Facility Name (If not institution, give street and number) Southern Maryland Hospital	Clinton		Prince Ge	orge's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 367 40 1107 1 M 2 F 67 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea June 24,	9. Birthola	ce (State or Foreign
pug A		Usual Residence of Decedent 10b. County 10c. City, Town or Loc	ocation		10	d. Inside City Limits
Maryla 1 • ho	ō	Maryland Prince George's Clinton				1 ☐ Yes 2 No
r 28a	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Count	ry?
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland imperiment of Health and Mental Hygiene. Imperiment: if item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be notified at once.	by Funeral	1 [Never Married 2 [Warried 17 Was 2 [NO 17 - +	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: W	
Maryland 21215-0036 nd 2 should be filed within 72 hours aft lith and Mental Hygiene. 27 is marked other than "natural", or rerematic event, the Medical Exact rearnalics.	Completed	(Specify only highest grade completed) (Give life. Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of works DO NOT use retired)	ing	Kind of Business/Indi	ustry
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Mary nd 2 shou lith and M 27 is mar		19a. Informant's Name/Relationship (Type, Print) Kum Cha Pace (Wife) 19b. Mailii 630	ng Address (Street and Number or Rura 7 Florence Court,	Clinton, I	y or Town, State, Zip o ID 20735	Code)
Baltimore, permit. Pages 1 ar Depertment of Hea importent: if item any injury or oths			osition (Name of matory or other place) Veterans Cemetery		Location - City or Tov Cheltenham	
Baltil permit. P Depertmit importer any injure		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Lee lexandria Ferry Ro	Funeral H	•	6633 01d 735
Physician /Medical		23a Part . Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	O .	or respiratory arrest,		Approximate Interval Between Onset and Death
Examiner		Due to (onas a consequence or):				
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BOX ath cert	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	y Day Year
That deb	þ	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.		o use contribute to the	e cause of death?
of Vital Records, P. Physician: The law requires that in this certificate has been signed be aral director, page 2 should be deta	Completed			24a. Was an autopsy performed 1 Yes 2 🖺	death?	esy findings available apletion of cause of
of Vita Physician: this certific	Be	25. Was case referred to medical examiner? Hospital:		h (Check only one)		
Of Phys	5	27. Manner of Death 28a. Date of Injury 28b. Time of		ome 5 Residence 28d. Describe how in)
ilon anding ath. rr: Afte	Certification;	1. ✓ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	M 1 Tes 2 No	28f Location (Street	and Number or Rural	Route Number
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he Hospitel in 24 hours he Funeral pletely filled	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or is and manner stated.	nvestigation, in my opinion, death occur	red at the time, date	and place, and due to	the cause(s)
To the within 2 To the comple	Σ	29b. Signature and title of certifier	29c. License number	fall 29d.	Date signed (Month, I	Day, Year)
7+1		30. Name and address of person who completed cause of death (Item 23a) (Type Bahram Rediace, MD 4457 Old Brand		Temple Hi	11s. MD 20)748
-	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ch Avc. Suite 201,			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2006 28272 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1032 Physician Lindsay Alexander Pratt, Sr. 5,2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Makyland Greneral LAMURO Her I Year If Und ŕ N/A If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 1 □ **X** 2 □ F Hours Yrs. Director 220-36-5168 Aug 11, 1941 Maryland Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 □XYes 2 □ No Completed by Funeral Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1648 Lorman Court 21217 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Warried 1 ☐ Yes 2 ☐ XNo Specify: Baltimore, Maryland 21215-003 Specify 3 ☐ Widowed 4 ☐ Divorced Black "natural" 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) United Longshoreman Longshoreman 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Giant Pratt Lily Virginia Pratt P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Donna C. Pratt 19 North Kossuth Street Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of important: if it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/11/06 Timonium, Md **Dulaney Valley Memorial Gardens** 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer metastatoc **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed attending physicien and for use as the buriaf-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, been signe should be d Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has l irector, page 2 s autopsy performed 1 Yes 2 🗆 No 1 Yes 242 No or Attending Physician: director, Be 25. Was case referred to medical 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dinpatient Certification; To 2000 1 ☐ Yes 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical comple ely To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) erson who completed cause of death (Item 23a) Type, P in beyand Greneral Hospital CoradateReva 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

06-06627

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Joseph Parzynski 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day September 4, 2006 1700 hrs Medical Examiner Parzynski Joseph Peter 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3123 Fait Avenue Baltimore n/a 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Mary Land 5. Social Security Number If Under 1 Year If Under 24Hrs 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Director 216-07-9002 93 July16,1913 $_{1}X$ 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 X Yes 2 No s 23a or 28a-f show e notified at once. 28a-f show Md. n/a Baltimore imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland neutr of Health and Mental Hygiene
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country 3123 Fait Avenue 21224 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 Yes 2 X No White 3 X Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify þ Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) the Medical tem 27 is marked other than ' traumatic event, the Medical Fence Weaver Anchor Fence Com. 7th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (unk) (unk) æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2419 Fait Avenue Baltimore, Md. 21224 19a. Informant's Name/Relationship (Type, Print) Adolph Lindemann (nephew) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, or other St.Stanislaus Cem 1 X Burial 2 Cremation 3 Removal from State 9/8/06 Baltimore, Md. niportant Other Specify Donation 5 22. Name and Address of Facil Maczorowski Funeral Home, PA 21. Signature of Funeral Service Licens 200 1201 Dundalk Ave. Baltimore, Md. Part I. Enter the disease, or complication failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Between Onset and Physician /Medical Death a. Head and neck injuries Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and trans Physician/Medical UNPENDED AMENDED attending physician or use as the burial -Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Month 2 past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown 9 Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o ģ م Yes 2 ✓ No 3 Probably 4 Unknown Colon cancer Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy hasl performed? this certificate ✓ Yes 2 No 1 🗸 the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene 1 V Yes After t 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Subject fell FOUND: Natural 1 Yes 2 V No Pending death. Funeral Director: Sep 4, 2006 1645 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 3123 Fait Avenue, Baltimore, MD (Specify) Townhouse / Rowhouse Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical the 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number mos O.C.M.E. September 5, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

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hysici /Medio		Decedent's Name (First, Middle, Melva A. Powell	Last)				2. Date of Death Month D	01 Yea	3. Time of Death	
Examir		4a. Fecility Name (If not institution, Sinai Hospital	give street and number)		4b. City, Town, o	r Location of Death	4	4c. County of Death n/a		
ineral rector		213-52-8061	6. Sex 7. Age 1 ☐ M 2 😿 F	(In yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day Yea 11/07/194	9. E	Birthplace (State or Fore Country) MD	
B-f show	tor	Usual Residence of Decedent 10a. State 10b. County n/e	a	10c. City, Town or Lo				10d. Inside City Limit		
3a or 28	il Director	10e. Street and Number 3407 Park Heights A	venue		10f. Zip Code	21215	10g. (Citizen of What US	Country?	
Importent: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic svent, the Madical Examinar must be notified at office.	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 1 Yes 2 1 N If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cuba	14. Race - Ar Black, W Specify: B				
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irked othe	To Be C	17. Father's Name (First, Middle, L. Melvin Dowell	ast)				(First, Middle, Maide	nknown en Sumame)		
or trauma		19a. Informant's Name/Relationshi Michael Powell / Hus				and Number or Rura ts Avenue; E				
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To the	Me	29b. Signature and title of certifier Lucille 30. Name and address of person w			29c. Licenso	e number - 9036	29d. D	pt. 5, 3	nth, Dey, Year)	
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DHMH 17 Rev 1/2001

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	Examir				ve street and number)	1		4b. City, Town, o	or Location of Deat	h ¥	4c. County		. 1
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D	ter de Instru	-un	11. Marital Status 1 □ Never Mari	ried 2 Married	12. Was Decedent Armed Forces	?	.5.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	to Rican, etc.)	Blac	ck, White,	etc.
ر م م	urs al	by	3 Widowed		If Yes, Give Year or Dates:			1□Yes 2€ No	Specify:		Specifi	w whi	te
ε 215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinal must be notified an once.	Completed by Funeral Director	(Spe	15. Decedent's E	Education rade completed)			dent's Usual Occup	pation during most of wo	rkına	16b. Kind of B	usiness/In	dustry
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LE ary	shound Mind Mind Mind Mind Mind Mind Mind Mi	1		lame/Relationship	(Type, Print)		19b. Mailir	ng Address (Street	and Number or Ru		er, City or Town,	State, Zip	Code)
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) (of He of He f Item		20a. Method of Dis	•	☐Removal from State	20b. P	lace of Dispo emetery, cres	sition (Name of matory or other pla	ісе)	Date	20c. Location -	City or To	own, State
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Z.	ysician: The lav is certificate has director, page 2	Be	25. Was case refe examiner?		Hospital:			Ott	hom	ath Check only			
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on	nding Phy th. : After thi s funeral o	tior	1 Natural 2 Accident	5 Pending investigated	(Month, Da	y Year)	injury	Wo	ork?]Yes 2□No		,,		
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ä	rs afte	Certification:	+ _ Tiomicido		bullding, e	ic. (Specii)	"			City or roll	wn, State)		
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	To the h within 2 To the I complet	Med	one) 29b. Signature and		and manner st	ated.		29c. Licens			29d. Date signe		
	7. × 00		b Signaturo and	A	- G A				3977		The day	/L	0.00/
			30. Name and add	Fressof berson who	completed cause of	death.(Item	23a) (Tyne	Print)	-11/	N	MININA	7	Lu G.
6	7		Question	10.5	30	Haz	-1-1	Done Ch	in Arm	not de	1. 2	101	,

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 28276 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 03 2006 11:40 pm **Physician** Reyes Carolyn Ann /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner n/a Baltimore 2001 Casadel Ave. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 24,1950 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Country Mary Land Months Days Hours Min. 1 ☐ M 2 🗹 F Yrs. 219-56-3738 55 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show I 2 should be filed within 72 hours after death with the Maryla n and Mental Hygiene. It is marked other than "natural", or itema 23a or 28a-f show it is marked other than "natural", or itema 23a or 28a-f show it is marked other than "natural", or itema 23a or 28a-f show it amartic awant, it is Martical Examinar must be nutilised at 1 ☑ Yes 2 ☐ No Maryland N/A Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21230 U.S.A. 2001 Casadel Ave. 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Seward Geraldine Nash James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
eny injury or other trau 12021 Mason Drive Quantico Virginia 22134 Dianna E. Bonincontri (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Brooklyn Park Maryland Cedar Hill Cemetery 9/8/06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee McCulfy-Polyniak Funeral Home, P.A. 130 East Fort Ave. Baltimore, Maryland 21230 Approximate Interval Between Onset and Death 23a. Part# Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 60102 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No
9 Unknown 4 Pregnant at time of death 5
Other (specify) P.O. 9. Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 □Unknown certificete hes been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 212 No 1 TYes 1 Yes After this certific funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 ☐ No Medical Certification; To 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40854 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimon 21202 301 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

2006

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State of Maryland / Department of Health and Mental Hygien 2006 28277 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** H:00 PM BURAZA 144057 18 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death University of Manuary Medical (entry)

5. Social Security Number

6. Sex

1XM 2 F

7. Age (In yrs. last birthda)

Yrs. Examiner Balthmore Baltimore, If Under 1 Year If Under 24 Hrs. 8.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** INDIA Director muny 4, 1946 Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. It is Maclical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits HARFORI ABING DOY 1 □ Yes 2 Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? COURT, WEST 21009 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: ASICI f Yes, Give Year or Dates: Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FURNITURE MAKER/WEIDER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mulvammad Lubaida 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2718 PSCUtchway kun Dr. ODEnton, MD 21113 Mulhammacl Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ring Memorial PARK Awast 19,2006 21. Signature of Funeral Service Licens 4300 Walaish March Foreral Home rel Bathmore, ND 21215 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner e-required ECMC attending physicien and for use as the burial-transit i or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the a funeral director, pege 2 should be detached in 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 1 🗀 Yes 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner?

↑ Yes 2 □ No 26. Place of Death Check only one Other: 1 Inpatient Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funersi Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier (Check only one) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatur 10 ted cause of death (tem 33a) (Type, Print) Name and addres Jās. 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 28278 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Charlotte Robinson 1:00 AM 3 September 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital Baltimore of Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Sociat Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🖫 F Yrs 83 231-18-7841 Director NC Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Yos 2 No Director NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 4800 Seton Drive U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2₹☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 🏋 ☐ No Specify: Black Specify: 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) Coltege (1-4or 5+) 12th grade Domestic Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mente! permit. Pages 1 and 2 should be Department of Heelth end Mentel Important: If Item 27 Is marked any injury or other traumatic evone. Joe Bryant Charlotte Leach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Sheraton Road, Randallstown, Md 21133 John Bryant-Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Park 9/8/06 Randallstown, Md 21. Signatule of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part I. Enter this disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat **Physician** disease or condition resulting in death) Congestive Heart

Due to (or as a consequence of): Failure /Medical Examiner Acute Romal I DAY Sequentially list conditions, and cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-transit ettending physicien and for use as the burial-tran Division of Vital Records, P.O. Box 68760, resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? 1 Yes 2 3 No After this certifice funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 🗷 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 X Yes 2 □ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c, Injury at Work? 1 Naturat 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours effer death To the Funerel Director: 2 Accident the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3 0059062 MA September 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beltimore MA 21215 Chil Hansen MD. 2401 W Belvedere 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		4	State of Maryland / Department of Health and Mental Hygiene 1- For Amend item#, 29d, perMD,g859,9/7/06 Certificate of Death Reg. No. 2006 28279
	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Examili	eı	6500 Hopeton Ave Baltimore N/A
	Funeral Director		5. Social Security Number 6. Sex 1 Months Days Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) (Month, Day, Year) (Month, Day, Year) (Month, Day, Year)
	ס		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	72 hours after deeth with the Maryland natural', or itema 23a or 28a-f ahow disal Evaninar must be notified at	to	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 10d. Inside City Limits 10d. Yes 2 \(\text{No} \)
	or 28a	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	na 23a	Funerai I	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,
98	or itan	/ Fun	Armed Forces? If Yes, specify Cuban, Mexican, Puerio Rican, etc.) Black, White, etc. I Ves 2 No. Specify:
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Bai	permit. Pag Depertment Important: any injury once.		21. Signature of Fiberal Service Licensee 22. Name and Address of Ficility ChatMan - Harris tuneral How Sayo Reisters town Rd Baltimore Add 21215
			23a. Pent Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Onset and Death Onset and Death
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	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury
΄,	execut n and ial-tran	Examin	resulting in death) Last Due to (or as a consequence of):
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Box 6	leath certifica attending ph I for use as th	√/Mec	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery
	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1
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rds	w requires that s been signed b should be deta	ed by	avenia, Hypertension with Heart FAILIC 1 Yes 2 No 3 Probably 4 Unknown
Records,	ne law re s has be ge 2 sho	Completed	Hypothyrate, Almhermer Denentia, 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
	ician: The certificate rector, pag	e Co	Il yes 22 No 1 Yes 22 No 1 Yes 22 No
of Vital	Physician: this certificatal director, particular	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
	ding P. h. After ti funera		27. Manner of Death 1 Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how
Division	r Attanding er death. ractor: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State)
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	To the Hospitel or Attending Physicien: The within 24 bours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	Som to the	Σ	29b. Signature and fittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) September
	n		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
/ 	2		Allew Reilly, MD 80, Toll House Ave, D-1, Frederick, UD, 2170/
	Sta Registr	-	31. Date filed (Month, Day, Year) SEP 0 7 2006 32. Begistrar's Signature

		For Amend Item 2	Satape of Ma	ryle89	9 ,097 Ce	tificate of	lealth an Death		giene Reg. No.200	6 28280
		1. Decedent's Name (First, Middle, Last)						2. Date of De	ath /Day /	3. Time of Death
Physicia /Medic		MARY HELEN REVELS						Hugu.	St 24,20	186 722 am
Examine		4a. Facility Name (If not institution, give	street and number)	locas	41	ab City, Town, or	r Location of D	eath L	4c. County of	Death
	Щ	1/ DRYAND GREE	KRUL H	0507	al	If Under 1 Year	If Under 24	419		2. Rishelana (Class or Consider
Funeral		5. Social Security Number 6. Sex	7. Age]M 2⊠F	(Infyrs. ia:	st ointnaay) Yrs.	Months Days		Min. Date of Bir (Month, Da	th ly, Year) 04/1952	9. Birthplace (State or Foreign Country) NC
Director	-	240-94-7171 Usuel Residence of Decedent		54				007	04/1932	IVC
laryland show		10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits
Man Hed	to	MD		BAL	TIMOR	E				1 AYes 2 No
h the	lrec	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	nat Country?
th will	Funeral Director	351 HERRING CT.				21231	l		USA	
ems ems	ne	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S	. 13.	Was Decedent of H	lispanic Origin an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)		- American Indian, White, etc.
36 s afte	by Fu	1 Never Married 2 Married	1 ∐ Yes 2 ဩN If Yes, Give	lo		1 ☐ Yes 2 🕱 No	Specify:		Specify:	NATIVE
21215-0036 d within 72 hours after death with the Maryland giene. prihen "natural", or Items 23s or 28s-1 show in Modical Examinar must be invitted at	g p	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Edu	Year or Dates:	1	16a Dece	dent's Usual Occup	ation		16b. Kind of Bus	AMERICAN iness/Industry
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withi then	mc	Elementary/Secondary (0-12) 11TH	College (1-4or 5	+)		BORER			FACTO	ORY
0 7 7 4	0	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle	, Maiden Sumame)
Maryland nd 2 should be fill the and Mental Hy 27 to marked out r traumatic even	10 B	JOHN LOCKLEAR					MAEO	MIE BARNE	S	
Shou shou	_	19a. Informant's Name/Relationship (Ty	rpe, Print)		19b. Maili	ng Address (Street	and Number o	r Rural Route Numb	er, City or Town, S	tate, Zip Code)
and 2 and 2 ealth a n 27 te		JUDITH ANN LOWERY	/SISTER		66	25 MARNE	AVE.,	BALTIMORE	, MD 212	224
Baltimore, Maperill. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other tra	H	20a. Method of Disposition	Company from State	20b. Pla	nce of Disponent	sition (Name of matory or other place	ce)	Date	20g 6000000	DONNELL ST.
Pages nent of not: If its ary or o		1 ⊠Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	MT	. CAR	MEL CEMET	ERY 08	3/30/2006	BALTIMO	DRE, MD 21224
Balti permit. Departin Imports eny inju		21. Signature of Funeral Service Licens	ee //	/						, FNRL. HM.
m 82 8 8		Wesley	hant	2				AVE., BAL		1D 21231
		23a. Part1. Enter the disease or compl shock, or heart failure. List only or	ications that gaused ne cause on each lin	the death.	Do not en	ter the mode of dyir	ng, such as cai	rdiac or respiratory a	ırrest,	Approximate Interval Between
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/Medical		resulting in death)	Due to (or as	a conseque	ence of):)			Failure		
Examiner		Sequentially list conditions,	HEPRI	76	T) E	nue r	aik	RE		
Si ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):		Alcoh	ol Liver	Disease	
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8760, cate be executed by sician and the burial-transit	a E		223 13 (31 113							
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ords, P.O. Box 68 requires that the death certific een signed by the attending prould be detached for use as a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Date	of delivery
Box leath cert attendin	ciar	in the past 12 months?	1□Live birth 4□Pregnant at			☐Ectopic pregnanc: ☐ Other (specify) _	у		Mont	
P.O.	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
ds, Puires that signed b	y P	Part II. Other significant conditions co	ntributing to death be	ut not resul	ting in the u	inderlying cause giv	ven in Part I.	23e. Did	tobacco use contrit	oute to the cause of death?
rds puires n sign	Completed by	HILOHOI 1	1buse	2				10	Yes 2 □ No 3	3 ☐ Probably 4 ☐ Unknown
Cord	jet							24a. Was		ere autopsy findings available
Vital Rec	m _C								ormed? / de	ior to completion of cause of eath? □ Yes 2 □ No
m: T	ပိ	25. Was case referred to medical					26. Place of	1 ☐ Yes Death (Check only		7 162 20140
Visicia s cert	To B	avaminer? . /	Hospital: 1 Unpatie	ent 2 🗆 E	R/Outpatie	nt 3□ DOA Ott	200	ng Home 5□Res		r (Specity)
Physerthia		27. Manner of Death	28a. Date of Inju	rv :	28b. Time o				how injury occurre	
inding aff.: Aft	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	y rear,	Injury		Yes 2 □ No			
Division of Vital Records, I or Attending Physician: The law requires the deter death. Director: After this certificate has been signed in by the funeral director, page 2 should be controlled.	HC	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	ury - At hor	ne, farm, si	reet, factory, office			(Street and Number	r or Rural Route Number,
Disafter safter	Certification:		Dunaning, ox	o. (opcoy)					,	
Division of Vita Yo the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Phy	sician: To the best	of my know	vledge, dea	th occurred at the ti	me, date and p	place, and due to the	cause(s) and man	ner as stated. nd due to the cause(s)
in 24 in 24 the F iplete	Medical	one)	and manner sta	ated.				-		
with To I	2	29b. Signature and title of certifier	0 100	٨		29c. Licens	19dmun es		29d. Date signed	(Month, Day, Year)
		1 1/ Re line	M	N.		1 89	15/16		0124/6	18
		30. Name and address of person who e	empleted cause of d	leath (Item,	23a) (Type	Print)	and	Gonos	no Xli	Korta O
		31. Date filed (Month, Day, Year)	32 Planietr	ald Signat	Magalla	11 Wyll	NILL	UNINC	uc 170	priac
Sta	te ar	CED 0.7 2006	32. Registr	U A						

			For State Registrar	State of Man		epartme Certifica					giene 200	6	28281
	Physici	an	1. Decedent's Name (First, Middle, Last) Philip Thor	nac D	andall					2. Date of Dea Month		ar	3. Time of Death U3PM
	/Medic Examin		4a. Fecility Name (If not institution, give s	treet and number)		,		Location	of Death	Sep	4c. County of D	eath	
	Funeral		Baltimore Washing 5. Social Security Number 6. Sex	7. Age (/	I Cente	nday) If Unde	er 1 Year	Burn If Under		. Date of Birth	Anne A		ace (State or Foreign
	Director		215-40-6567 Usuel Residence of Decedent	M 2 F	62 Y	rs. Months	Days	Hours	Min.	pril 2	23° 1944	Coun	MD MD
	aryland show	7	10a. State 10b. County		Oc. City, Town	or Location	D					11	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
3	n the M	irecto	Maryland Anne Ar	undel		10f. Z	ip Code	saden			10g. Citizen of What		
Sa	aller death with the Marylar or Itema 23a or 28a-f show miner must be notified at	erai D	1515 Colony Road	2. Was Decedent Eve	ar in II S	12 Was Doo	adopt of H	211		fy Yes or No-	14. Race - A	JSA	an Indian
Dam 5-0036	ours after de rai', or item Examoner	by Funeral Director	1 Never Married 2 Marned 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	91 III O.G.	If Yes, sp	ecify Cuba	Specify:	n, Puerto Ri	can, etc.)	Black, V	Vhite,	
1215-0	within 72 hours after death with the Maryland ene. then "netural", or Itema 23a or 28a-f show he Medical Examiner must be notitied at	To Be Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a.	Decedent's Us (Give kind of w life. DO NOT Truck	ork done use retire	during mos 1)	st of working		16b. Kind of Busine		·
Jund	be filed with stat Hygiene od other the event, the	Be C	17. Father's Name (First, Middle, Last) Thomas Robert	Randall	Sr.						Maiden Sumame)		
Phi	d 2 should the and Ment 7 is marked traumatic e	2	19a. Informant's Name/Relationship (Typ	e, Print)	19b.				er or Rural I	Route Numbe	r, City or Town, Stat	te, Zip	Code)
	1 an Heal em 2		Sue A. Randall 20a. Method of Disposition	(spou	20b. Place of	Disposition (Na	ame of		Dat		1D 21122 20c. Location - City	or To	wn, State
3altimore	Se do		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		, crematory or aven Ce			Sept. 200	09	Glen Burn		
Balt	permit. Page Department of Importent: If any Injury or once.		21. Signature of Funeral Service License	\times ∂ .		22. Name a			. 21	calling 1. Pasa	ıs Funeral Idena, MD	Ho 211	ome, P.A.
			23a. Part1. Enter the disease, or complishock, or heart fail re. List only of Immediate Cause (Final	ations that caused the cause on each line.	e death. Do n	ot enter the mo	de of dyir	ig, such as	cardiac or	respiratory arr	rest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a c	-/-	f):	, 6	1	606	oA.	ne L	9 0	disose.
	9	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	End Due to (or as a o	consequence of			on	C 65	8,000		حا	your.
	sicien end	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	consequence of	nyo)	pul	N.				+	Joan.
68760,	cate phy:	dicai	L	Chroso	wic	hors	हों र	, bi	77	aile	···		2 yeurs.
P.O. Box (To the Hospital or Attending Physicien: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificete has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 [4 ☐ Pregnant at tirn 9 ☐ Unknown	Fetal death	3 ⊟Ectopic 5 □ Other (s		,			23d. Date of Month		ry Day Year
	quires thet an signed b		Part II. Other significant conditions con	tributing to death but r	not resulting in	the underlying	cause giv	en in Part	l.	23e. Did to	es 2 No 3	te to th	
Reco	ne law re hes be- ge 2 sho	Completed	Hyperten	m.						24a. Was a autop perfor	an 24b. Were sy prior med2 deat	n'/	osy findings available appletion of cause of
ital	zien: Th artificete ctor, par	Be Co	25. Was case referred to medical examiner?	C/200/+	3				e of Death	1 ☐ Yes Check only or	2000 11	Yes	No
Division of Vital Records,	g Physic er this co	ုင္	1 ☐ Yes 2 No H	28a. Date of Injury (Month, Day Y	2 / SP/Out 28b. T		28c. Injur Wor	4 🗀 🖂			ence 6 Other (Specify	′)
ision	death. ctor: Aft y the fun	Certification:	Natural 5 Pending investigation 3 Suicide 6 Could not be	28e. Place of Injury		М	10	Yes 2□		If. Location (S	treet and Number o	r Rura	I Route Number
Div	utal or A	Certi	4 Homicide determined	building, etc. ((Specify)				d	City or Tow	n, State)		
	n 24 hou n 24 hou ne Fune sletely fil	edicai	29a. Certifier (Check only one) Certifying Physical Examination	ician: To the best of r er: On the basis of ex and manner state	camination and	death occurre Vor investigation	d at the tir on, in my o	ne, date ar pinion, dea	nd place, an ath occurred	d due to the d d at the time, d	cause(s) and manne date and place, and	r as st due to	ated. the cause(s)
	To the To the Comp	M	29b. Signature and 1816 of certifier	-			9c. Licens		77	à	29d. Date signed (M	fonth,	Day, Year)
	10	8	30. Name and address of person who con GURMEET . S . S. S. 31. Date filed (Month, Day, Year)	mpleted cause of dear	th (Item 23a) (Type, Print)	J.	177	112	10100	CUEN	B	unter
1	Sta	te	CIURMEET S. ST. 31. Date filed (Month, Day, Year)	32. Registrar's	Signature	325 H	12	i i act		76106	_ 0/100	ul	21061
	Regist		SEP 0 7 201	16 Descar	J. J. J.	SOBALL.							

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene Heather Marie Spindler

		1- For State Registrar		rtificate of	Death	,,	Reg.	$_{No}$ 201	06 282
Physio ledical Exar		1/ / 1					Date of Death		3. Time of Death
euicai Exai	me	INCHINE MARKIE	SPINDLER				Month Da September 3	, 2006 Year	2156 hrs
		4a. Facility Name (if not institution, g Baltimore Washimngton		4	b. City, Town, or Local	tion of Death		4c. County of Dea	
Funera					Glen Burnie			Anne Arunde	el
Directo			Sex 7. Age (In yrs.	last birthday)			B. Date of Birth (N	Tear	irthplace (State or
			M 2 V F	Yrs.	Working Days H	lours Min.	8-7-8	35	country) MD.
any	1	Usual Residence of Decedent 10a. State 10b. County							
*		MA A		Town or Location					10d Inside City Limits
Maryland 28a-f show	ğ	MY ANNEA	rundel C	> EN t	SURNIE				1 Yes 2 No
r 28a	Director	10e. Street and Number			10f. Zip Code		10g. (Citizen of What Co	untry?
5-0036 ed within 72 hours after death with the Maryland tygene other than "natural", or items 23a or 28a-f sho	<u>-</u>	1432 TURNACES	ranch Ro.		2106	00	1	5-A.	
tth wi	Funeral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was	Decedent of Hispanic s, specify Cuban, Mex	Origin? (Specif	y Yes or No-		rican Indian, Black,
er de	F	O Duce	1 Yes 2 No	i			an, etc.)	White, etc.	8.
rs afte arral"	≦	The same of the sa	d If Yes, Give Year or Dates:		Yes 2 No spe	,		Specify: Wh	ITE
2 hou "nat	Completed	15. Decedent's Education (Specify of Elementary/Secondary (0-12)		16a. Decedent during mo	s Usual Occupation (G st of working life, DO N	Sive kind of work NOT use retired)	done 16	b. Kind of Business	/Industry
5-0036 led within 7/ Hygiene lother than	D G	Lienterial y/decordary (0°12)	College (1-4 or 5+)	」 し		•			1
5-0036 led within 7 Hygiene other than	E	17. Father's Name (First, Middle, Las	1)	toc	D SERVE		F		2VICE
		ROBERT EDWARD			18.Mo	ther's Name (Fire	st, Middle, Maid	en Surname)	
2121 buld be fi Mental I marked		19a. Informant's Name/Relationship (Type Print)	10h Martina	KEI	SECCA TO	AY TUC	KER	
imore, MD 21215 Pages I and 2 should be file ment of Health and Mental H, tant: If iten 27 is marked o	-	ROBERT E-SPINOL		QCx)	Address (Street and I			City or Town, Stat	e, Zip Code)
and and lealth item	-	20a. Method of Disposition		Place of Dispositi	on (Name of cemetery	Da Da		MD-210	038
OF ges 1 t of 1		1 Burial 2 Cremation 3	Removal from State	crematory or other	r place)			c. Location - City o	
Baltimore, permit. Pages I at Department of He Important: If ite injury or other tr		4 Doration 5 Other Specify	Ho	LY CASS	SCEMETER	4 9-9	-06 B	200KZYNA	HEK, MD.
Baltimore permit. Pages 1 Department of F Important: If injury or other		21. Signature of Fune al Service Lice	A	_	me and Address of Fac Daugherty Family F	cility	A = d O C -	0 / 5	
Physician	-	3a Part I Enter the diseas, or my failure. List only one colors on e	oligations that	D	2601 Mounts	ain Road - Pa	And Crematio	n Center, P.A.	
/Medical		failure. List only one case on e	don mic.					hock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease a or condition resulting in death)			e intoxicatio	on and coc	aine use		Death
			Due to (or as a consequence of	·):					
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	(i):				-	
	盲	cause. Enter Underlying Cause (Disease or injury that initiated C.		<u></u>					
ed	Examine	events resulting in death) Last	Due to (or as a consequence of):					
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed bin 24 hours after death. The succession of the second of the second of the attending physician and one pletely filled in by the funeral director, page 2 should be detached for use as the burial - transit		d							
760, ficate be exe g physician g the burial -	n/Medical	X UNPENDED	#23a,27,28a	-f,perME,g	860, 10/30/0	6 TT			
18760, tificate be ng physicial as the buri	W/U	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome or pregr	iancy			2	3d. Date of deliver	<u>, </u>
Sox 6. death cert e attendin for use a		past 12 months?	1 Live birth 4 Pregnant at time of dea	ath	death 3 Ecto	opic pregnancy		Month [Day Year
Box ne death o the atten	Physicia	1 Yes 2 No 9 ✓ Unknowr	9 Unknown	5 Othe	r (Specify)				
P.O. that the ned by t detache		Part II. Other significant conditions	contributing to death but not re	sulting in the und	derlying cause given in	Part I.	23e. Did tobacci	use contribute to	the cause of death?
ires that signed be deta	d by					- 1			pably 4 Unknown
ords, w requires to been a should	Completed					\	24a Was an		topsy findings available
CO e law e has e 2 st	п					[autopsy performed?	prior to c	completion of cause of
tal Recian: The	ខ	OS W.				1	Yes 2		s 2 No
ital iician s certi	B	25. Was case referred to medical examiner?	dospital:		26.Place of Dea		ne)		
Division of Vital Records, P.O. tal or attending Physician: The law requires that the safter death all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detack	입	1 Yes 2 No 27. Manner of Death	i V inpatient 2	ER/Outpatient 3			me 5 Resid	ence 6 Other	
no iding h Afte	등	1 Natural -	28a. Date of Injury (Month, Day,Year)	28b. Time of Inju		. 1	Describe how in	jury occurred	
Division spital or Attendours after death teral Director:	Certification:	2 Accident Pending Investigation	on Fnd 9/2/2006	Fnd 5:10		-	cnown		
Divi		3 Suicide 6 Could not			_	etc. 28f. L	ocation (Street	and Number or Ru	al Route Number, City
Spita hours neral	Ö	4 Homicide determined	(opeciny) Louis a	at residen		Apt.	6, GLen	Burnie, MD	ral Route Number, City e Branch Road
ne Ho n 24 ne Fu	cal	(Check only	an: To the best of my knowledge	e, death occurred	at the time, date and	place and due to	n the cause(s) a	nd mannor as start	ed
Di To the Hospital within 24 hours a To the Funeral I	Medical	2 Medical Examiner	On the basis of examination and manner stated	d/or investigation	, in my opinion, death	occurred at the t	ime, date and pl	ace, and due to the	e cause(s)
	2	29b. Signature and title of certifier			29c. License number	er	29d.	Date signed (Mor.	th, Day, Year)
		my h	, mis		O.C.M.E.		Se	ptember 5, 200	06
		30. Name and address of person who o							
		Ling Li, MD Assistant M	edical Examiner 111 F	Penn Street,	Baltimore, MD 21	1201			

			For State Registrer	ate of Maryland	d / Depa <i>Cer</i>	rtment tificate	of Healt of Dea	h and M	ental Hy	giene Reg. No.	06	28283
	Physici		Decedent's Name (First, Middle, Last) DODOTHY C SNOWDEN						2. Date of De. Month	Day	Yeer	3. Time of Death
	/Medic	al	DOROTHY G. SNOWDEN 1a. Facility Name (If not institution, give street	and number)		4h City T	Town, or Locati		-EPTEN	4c. County		01.25AM
	Examin		_	on MEIXCAL	CEN	TER	GLER	1. Bus	ZNIZ	Ann	4	PUNDEL
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2	7. Age (In yrs. la		If Under Months	1 Year If Un Days Hou	der 24 Hrs. rs Min.	8 Date of Bird (Month, Da JAN 26,	h y, Year) 1935	9. Birthpli Count BAL	ace <i>(State or Foreign</i> lry) TIMORE
	pue .		Usuel Residence of Decedent 10a. State 10b. County	10c. City	. Town or Lo	cation					10	Od. Inside City Limits
	Maryle fatto	ō	MD ANNE ARUNDEL		SSUP							1 □ Yes 2 □ No
	r 28e	Irec	10e. Street and Number			10f. Zip	Code			10g. Citizen of	What Count	try?
	th with	aiD	7810 CLARK RD. #D75			207				USA		
36	d within 72 hours after death with the Marylend Jiene. I than "natural", or Items 23a or 28e-f ahow The Madical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married 1	as Decedent Ever in U.S med Forces? ☐ Yes 2, ☐ No Yes, Give X ear or Dates:	li li	Vas Decede Yes, speci ☐ Yes 2	ent of Hispanic ify Cuban, Mex No <i>Spe</i>	rican, Puerto F	cify Yes or No Rican, etc.)	Bla	ce - America ck, White, e	etc.
2-0	72 hou		15. Decedent's Education (Specify only highest grade com		16a. Deced	lent's Usua kind of wor	Occupation	most of workir	na	16b. Kind of E	lusiness/Ind	lustry
Maryland 21215-0036	ne.	Completed	Elementary/Secondary (0-12)	ollege (1-4or 5+)	life. L	OO NOT us	e retired)					
d 2			12 17. Father's Name (First, Middle, Last)			HOMEM		other's Name	(First, Middle,	OWNI Maiden Sumai		
an	s 1 and 2 should be filed f Health and Mental Hyg Itam 27 is marked othe other traumatic avant,	To Be	WILLIAM BLANKENSHIP					MARIE S	TUBBS			
ary	2 should be and Mental is marked raumatic av		19a. Informant's Name/Relationship (Type, Pr	rint)	19b. Mailin	g Address	(Street and Nu	mber or Rura	i Route Numb	er, City or Town	, State, Zip	Code)
χ. Σ	and 2 m 27 m 27		KENNETH SNOWDEN SR.	HUSBAND	7810 ace of Dispo		RD. #D75		, MD 207	94 20c. Location	City or To	um Stato
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if Itam 27 is any injury or other tra ange.		20a. Method of Disposition 1 ☐ Burial 2√☐ Cremation 3 ☐ Remov	CA CA	metery, cren	atory or of	ther place)	1				wii, 5tate
altin	mit. Partme		4 □ Donation 5 □ Other (Specify) 21. Signature griffuneral Service Licensee	20	22	. Name and	d Address of F		, 2006	BALTIMO	RE, MD	
ä	Depa Depa Impo any is		1 Lincory	7.7	4:	26 CRAI	NERAL HON IN HWY SW	, GLEN , BI				
	Pnysician /Medical		23a. Part1. Enter the disease, a comblidation shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	LETASTA	10 F		of dying, such			rrest,		Approximate Interval Between Onset and Death
	Examiner			Due to (or as a consequ	ence of):							
		ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	Due to (or as a sonsequ	ense of):							
	ate be executed hysician end the burial-transit	Exam	Cause (Disease or injury that initiated events c.	Due to (or as a consequ	ence of):							
8760,	sician buria	· 65			01,00 01,							
9	tificate I g physi as the b	ledic	0					7,0,00				=17
.O. Box	at the deeth certific by the ettending p	Physician/Med	in the past 12 months?	yes, outcome of pregnar □Live birth 2 □ Fetal □Pregnant at time of de □ Unknown	death 3	Ectopic pre Other (spe					ate of delive onth	ry Day Year
Δ.	gned be de	፩	Part II. Other significant conditions contribut	ting to death but not resu	Iting in the u	nderlying ca	ause given in P	art I.		obacco use cor Yes 2 ☐ No	tribute to th	ably 4 Dunknown
of Vital Records,	The law requireste has been single as page 2 should lead to the last been single as the last beautiful to the	Completed)		-					rmed/	death?	psy findings available inpletion of cause of
ta		0	25. Was case referred to medical				26. F	Place of Death	1 ☐ Yes	2 No	1 Yes	2L No
Ž	\$ s 5	ToB	examiner? 1 ☐ Yes 2 ☑ No Hospit	al: 1 Inpatient 2 ☐ E	ER/Outpatier			☐ Nursing Hor	ne 5⊡Resi	dence 6 □Ot	her <i>(Specif</i> y	()
o L	ding Ph h. After th funeral		1 SNatural 5 ☐ Pending	a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 2	8c. Injury at Work?		28d. Describe	how injury occu	rred	
Division	Attan r deatl ector: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	e. Place of Injury - At ho building, etc. (Specify	me, farm, str				28f. Location (City or To	Street and Num wn, State)	ber or Rura	l Route Number,
_	Hospita 4 hours Funsraties ely filled	edical Ce	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: 6									
	To tha within 2 To tha complet	Me	29b. Signature and tiller of centifier				. License numi			29d. Date sign		
			1 12 Locat	2	Mi	>	1742	49		septen	nber	5 2006
	17		30. Name and a viess of person who comp	ted cause of death (Item	23a) (Type	Print)	rue	Gien	Bwa	we m	D. :	52006
	Sta Regist		31. Date filed (Month, Day, Year) SEP 0 7 2006	32. Registrar's Signal	sure And	after!						

brothy Snowden

State of Maryland / Department of Health and Mental Hygiene 2006 28284 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:20 AM am 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Himore Medical Certe Baltin VA If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Virginia 8. Date of Birth (Month, Day, Year) Jul 17, 1923 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 1 DM 2 F 230-78-0061 Director 83 Usual Residence of Decedent Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow must be notified at **Baltimore** 1 Yes 2 No N/A Maryland Director the 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 2503 Violet Avenue 21215 U.S.A or iteme 23a Funeral 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examinar Black, White, etc filed within 72 hours after 1 Never Married 2 Married ☐XYes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ KNo Black Specify: Specify: ģ 3 XWidowed 4 Divorced Year or Dates: "natural" Completed 15. Decedent's Education (Specify only highest grade completed, 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Bethlehem Steel and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Foreman 12 treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill ment of Health and Mental Hent: If Item 27 is marked off jury or other treumatic even Be Etta Spady Lloyd Spady ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2503 Violet Avenue Baltimore, Maryland 21215 Alfonso Spady 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department importent: if any injury or once. 09/11/06 Owings Mills, Md Garrison Forest Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lig 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner cance ostate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Exami physician and Due to (or as a consequence of): Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> icete hes been sig 1, page 2 should b 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, 1 Yes 2 No Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ŝ 29b. Signature and title of certiful 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 South Greene Street Baltimore Albert M. O. 22 31. Date filed (Month, Day, Year) State 7 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 20061 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 620PM varren September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Johns Hopkins Bayview Medica Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 07/01/1930 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** 1፟፟፟M 2□F Director 76 Yrs. 217-24-7640 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heelth and Mentel Hydene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any Injury or other traumatic avent, the Medical Exam are must be routlised at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 U.S.A. 2419 Brunswick Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ring most of working College (1-4or 5+) Elementary/Secondary (0-12) Iron Worker Local 16 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Warren Shannon Sears Florence Virginia Reibert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary Sears / wife 2419 Brunswick Road; Halethorpe, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 09/11/2006 Stevensville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, PA and Moi357 1 Second Ave SW; Glen Burnie, MD 21061 23a. Part1. ENarthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) xPSis **Physician** Fair Days /Medical Due to (or as a consequence of): Examiner neumonia For Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death signed by the a 5 Other (specify) Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 1 ☐ Yes 2 ☐ No been si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate hes al director, page 2 autopsy performer res 2 2□ No 1 ☐ Yes 1 ☐ Yes of Vital within 24 hours efter death. To tha Funeral Director: After this certific complately filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) Medicai Certification: 27. Manner of Death 28d. Describe how injury occurred Division Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital Certifying Physician: To the hest of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and maintain as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) sellin so Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Iverue, Raltimore, Maryland 21224 Brian Silverman 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 7 2006 Registrar

ORIGINAL

			1 For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of H	lealth and l		giene 2006	28286
			Decedent's Name (First, Middle, La	st)				2. Date of Dea	th	3. Time of Death
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	Examir		4a. Facility Name (If not institution, giv	4b. City, Town, o	or Location of Deat	h	4c. County of Dea	th		
			Harbor HOS		the second beautiful at	If Under 1 Year	TMORE If Under 24 Hrs.		N/A	
l	Funeral Director		213 26 1003	C 27 -	76 Yrs. last birthday,	Months Days	Hours Min.	8. Date of Birth (Month, Day Dec. 21	, 1929 Ma	thplace (State or Foreign ountry) ryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Mary -f •hc	ţ	Maryland Baltimo	ore	Baltime	ore				1 ☐ Yes 2X☐ No
	r 28s	Director	10e. Street and Number			10f. Zip Code		1	log. Citizen of What Co	ountry?
	th wil	aiD	4230 Hollins F	erry Road	Apt. 116	212	227		U.S.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene important: if item 27 is marked other then "natural", or items 23e or 28e-f show stry injury or other treumatic event, its Medical Engities maint be recitied at ance.	Completed by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 N If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cubin 1 ☐ Yes 2X No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	te, etc.
21215-0036	72 hor	ted	15. Decedent's E		16a. Dece	dent's Usual Occup	pation	4.7-	16b. Kind of Business	/Industry
2	ithin 7	nple	(Specify only highest gra	College (1-4or 5-	+)	kind of work done DO NOT use retired	during most of wor d)	rking		
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anc	ntal Find of	Be	17. Father's Name (First, Middle, Last,	rd Willefo	rd			ne (First, Middle, I 7 Adams	Maiden Surname)	
Maryland	should nd Men marke imatic	ို	19a. Informant's Name/Relationship (no Address (Street			r, City or Town, State, a	Zin Code)
	and 2:		William Savoie /						6 Baltimor	
ore,	of Her		20a. Method of Disposition		20b. Place of Dispo				20c. Location - City or	
<u>Ĕ</u>	Pages ment of ant: if it ury or o		1 🖾 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif			11 Cemete		2006	Baltimore,	Maryland
Baltimore,	permit. Pag Depertment Important: if any injury o		21. Signature of Funeral Service Licer	nsee					eral Servio imore, Mary	ce, P.A. yland 21225
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each line	the death. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. ACUTE	RESPIR	ATORY	FAILUR	E		Onset and Death 5 HOURS
	/Medical Examiner		resulting in death)		consequence of):					5 110075
		_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. CHRONIC	consequence of):	TIVE PL	LMONAR	LY DISEA	SE	
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9		Med	IF FEMALE:							
Вох	ath ce ttendi	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death 3	Ectopic pregnancy	,		23d. Date of del	ivery Day Year
o.	The law requires that the death certify ite has been signed by the attending bage 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at t 9☐ Unknown	ime of death 5	Other (specify)			World	Cay
۵.	res that tigned by	P.	Part II. Other significant conditions o	ontributing to death bu	t not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
Records,	quires n sign	d by	LUNG CANCE	FR				1 □ Y€	es 2□No 3MPr	robably 4 Unknown
000	sw requir s been si s should	ojete						24a. Was a	n 24b. Were au	itopsy findings available
æ	sicien: The lav certificete has irector, page 2:	Completed						autops perform	V / Drior to i	completion of cause of 2□ No
Division of Vital	ysicien: is certifice director, p	Bec	25. Was case referred to medical examiner?				26. Place of Dea	th Check only on	11000	2010
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Ĕ	Attending Physicien: r death. ector: After this certific by the funeral director,	ertification;	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Worl		28d. Describe ho	w injury occurred	
18	or Attencatter death Director: in by the	icat	2 Accident investigation 3 Suicide 6 Could not be		y - At home, farm, str		Yes 2 □ No	206 Location (Ca		
<u>^</u>	after after Direction	ertit	4 Homicide determined	building, etc.	(Specify)	eet, ractory, onics		City or Town	reet and Number or Ru n, State)	irai Houte Number,
	To the Hospitel or Attentwith 24 hours after deall To the Funeral Director: completely filled in by the	edicai C	29a. Certifier (Check only one)	ysician: To the best of the basis of and manner state	examination and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occur	, and due to the ca rred at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
	within 2 To the complet	Me	29b. Signature and title of certifier	A		29c. License	e number	2	9d. Date signed (Monti	h, Day, Year)
	1		Marine E	mo de	ine Mit) PES	5000	S	EPTEMBER	4 2006
	'n		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type,	Print) MAR	INAE	BOROD	KINA	
	J		HARBOR HOSPI	TAL 300	1 1000-11	HANOV	ER STI	REET F	BALTIMO	RE MD 21225
	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registra	s Signature	Annell "				
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State of Maryland / Department of Health and Mental Hygien 2006 28287 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Sptember 6, a 2006 9:22 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1527 Light Street Baltimore 8. Date of Birth (Month, Day, Year) Oct. 17, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours Min Months Days 1 ☐ M 2 🙀 F 68 Yrs. 219-34-3401 1934 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
ant: If Item 27 is marked other then "naturel", or iteme 23e or 28e-f ehow ury or other treumatic event, the Medical Exertices must be routined at 1 Ty Yes 2 □ No **Funeral Director** Maryland Baltimore n/a10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21230 1527 Light Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married ☐Yes 2☐No Yes, Give X Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed by Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8 years College (1-4or 5+) n/a Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Marie Baierlein 2 Harvey Gardner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William M. Tudor (husband) 1527 Light St. Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State permit. Page Department of Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 9-11-2006 Cedar Hill Cem. Brooklyn Park, Maryland 21. Si navre of Funeral Sovice Licensee McCully-Polyniak Funeral Home, P.A. 130 E. Fort Ave. Baltimore, MD 21230 J. Wayne Osterling 234. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (nal disease o condition resulting in death) Prysician Myocardia /Medical Due to (or a a consequence of) Examiner oronari Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner to the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physicien end for use as the burial-transit Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4☐Pregnant at time of death P.0. ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s has autopsy performed? 1 Yes 2 No after death.

Director: After this certific

in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 PResidence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28a. Oate of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire completely filled in b Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 6,2006 3250 Starting Gate (+ woodbine md who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Stefanacci 31. Date filed (Month, Day, Year) 32. Registrar's Signature State poets SEP 0 7 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 28288 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 3, 2006 **Physician** Taylor 12:10 A M Mary Lee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Manor Care Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 16, 1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Marvland 90 215-03-8879 Yrs Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or items 23e or 28a-f ehow the Madical Examiner must be notified at MD Baltimore Towson 1 Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 U.S.A. 917 Starbit Road e filed within 72 hours after death val Hygiene.
other then "naturel", or items 23e 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 € No Completed by 3™ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home permit. Pages 1 and 2 should be flite Department of Health and Mental Hy Important: if item 27 is marked oth eny fluiry or other treumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Chiles Cecelia Mary Frank Fanning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas E. Taylor—son 917 Starbit Rd., Towson, MD 21286 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Hilltop Serv corp 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/6/06 Towson, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lansee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dementiq Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it may be conditions cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ng physician and as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 [] Unknown Part It. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Noknown 24b. Were aulopsy findings available prior to completion of cause of death? autopsy performed? certificete 1 ☐ Yes 2 No 2 To the Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ٥ 1 ☐ Yes 2 No After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Naturat 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours efter death To the Funeret Director: completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0061199 Sept, 5. 2006 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 North Charles ST, Su. to 209. Touson MD 21204 1Slack 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Registrar SEP 0 7 2006

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2006 28289 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician ILLERY 2000,12:19p HER BERT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner N/A Baltimore University Maryland Medical System If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) **Funeral** 1 🖹 M 2 🗆 F Yrs Director 217-38-3974 66 Aug 11, 1940 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits item 27 le marked other then "neturel", or items 23s or 28s-f ehow other treumatic event, the Madical Examinar must be notified at 1 Yes 2 No Lutherville Baltimore Director Maryland eq. 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 102 West Seminary Avenue 21093 U.S.A Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married ☐ Yes 2 🙀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify. Black à If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Lockridge Vocational Cetner Janitorial Engineer 12 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 le marked other t eny injury or other treumatic event, <u>I</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret C. Tillery Thomas Tillery ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3829 Elmley Avenue Baltimore, Maryland 21213 Pauline Brogden Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 09/01/06 Lansdowne, Maryland 4 □ Donation 5 □ Other (Specify) Mt. Zion Cemetery 21. Signature of Funeral Service Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death shock, or rear failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) one how **Physician** Ma /Medical Due to (or as a consequence of) Examiner CHVS Corona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Who
9 Unknown Month Year Dav 4□Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown ate hes been signed in page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 → No 24a. Was an certificate hes autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2 No 1 Inpatient ဥ 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? he Hospital or Attending Pt n 24 hours after death. he Funeral Director: After the pletely filled in by the funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 12 Certifying Physiciam To the best of my knowledge death occurred at the time, date and place, and dire to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 23s Conttor (Check only one) To the Vithin 2 Attending 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00037016 August 30, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENE, M.D 6701 N. CHARLES ST., STE 4105 BALTO, MD 2 1204 KENNETH M. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Bleen & Sports

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2006 28290 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** September 5, 2006 Evelyn Torrence 5:15P.[™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare-Heritage Dundalk Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 3, 1919 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 □XF 215-09-4380 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Mudical Examiner must be notified at 1 ☐ Yes 2 XNo Director Md. Baltimore Dundalk 10g. Citizen of What Country? 10e Street and Number 10f Zin Code ŏ 1961 Haselmere Road 21222 or Iteme 23a USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: Whi<u>te</u> 1 Yes 2 No Specify: à 3 ₩ Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry illed within 7 Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) Manager Banking other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Ie marked other any Injury or other traumatic avant 17. Father's Name (First, Middle, Last) Thurman Saunders Katherine Kohler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frances Diggs (daughter) 1961 Haselmere Road Dundalk, Md. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 9-6-2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility aczorowski Funeral Home, PA 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner OTHERMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner AND SMALL BOWEL ILEUS burial-transit Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 D No 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ MELLITCIS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 1 Yes 2010 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Dursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 212 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Datural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) se of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 28291 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2006 **Physician** Sept. 4, 11:11 PM Wickkiser Mary Jane /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Gilchrist Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 27, 15 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🛣 F Yrs. 1932 Pennsylvania 74 211-26-3446 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene. and the fitem 27 is marked other then "natural", or iteme 23a or 28a-1 show ant: If item 27 is marked other then "natural", or iteme 23a or 28a-1 show ary or other traumatic event, II a Medical Exactinat must be notified at 1 ☐ Yes 2 No Towson Directo Baltimore Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8426 Charles Valley Court Apt. D 21204 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ∐Yes 2 X No fYes, Give 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify. Baltimore, Maryland 21215-0036 Specify. 3 Widowed 4 Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Finance Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Eyster Henry Spahr Mary 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8426 Charles Valley Ct. Apt. D Towson, Md. 21204 Rev. Bruce D. Wickkiser/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 9/9/06 Department of Important: If eny injury or once. Dover, Pennsylvania Salem Union Cemetery | 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licenses 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Compleations disease or condition resulting in death) /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. porcuatic Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 No 5 Residence 6 Nother (Specify) Hospice ၉ this After this funeral of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 5 2006 758302 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

April (LED) W. U.M. 6601 No Clerkes 81 Barnere us zizoy

Registrar

State

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State of Maryland / Department of Health and Mental Hygiene 2006 28292 1 - Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D2006 Month **Physician** Aug. 31. Rhea 0'Malley Wright 10:50 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Center I DIJSUI I

If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

Min.

MOV. 7, 19 Baltimore 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XX 215-30-2225 72 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Heatilt and Mental Hyglene. If the attent and Mental Hyglene then "natural", or Iteme 23a or 28a-1 show other traumatic event, the Medical Executar rount be notified at 1 ☐ Yes 2XXNo Baltimore Md. Monkton Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3901 Allendale Court 21111 Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐ Yes 2XXNo Yes, Give 1 Never Married 2 Married $3//\theta \zeta$ altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Fleet Leasing Rep. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward O'Mallev Louise Knop ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depertment of Health and Important: If Item 27 is rr any injury or other traum 2002. Mr. John D. Wright, Jr./Son 3901 Allendale Ct. Mônkton, Maryland 21111 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillton Service Corp. 9/2/06 Towson, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Ruck Towson Funeral Home, Inc. 11050 York Road Towson, Maryland 212U4 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SMOKE Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) this certificate has been signed by al director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Ves 2 □ No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical 26. Place of Death | Check only one examiner's Other: 4 Nursing Home 5 Residence 6 Dother (Specify) NOSP(U Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA To the russing after death.

To the Funaral Director: After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Eccitifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chack only one) ş 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2006 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMIRS, un 6601 BAISMORE N- WARD 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State SEP 0 7 2006 Registrar

			For State Registrar	State of Maryl	and / Depa <i>Ce</i>	artment of H rtificate of L	ealth and M D <i>eath</i>	lental Hygiei Reg.	ne 2006	28293
	Physici	an	1. Decedent's Name (First, Middle, Last		LDE	0			Day Year	3. Time of Death 130 2 M
	/Medic Examin	al	4a. Facility Name (If not institution, give		LUE		Location of Death		4c. County of Death	1002
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H	Funeral Director		5. Social Security Number 6. Se	x M 2□F	yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye	ar) Coul	place (State or Foreign
	D .		Usual Residence of Decedent 10a, State 10b, County	100	. City, Town or Lo	ocation				IOd. Inside City Limits
	Maryis -f eho	tor	Maryland Anne Aru		Severn					1 ☐ Yes 2万No
	or 28s	Director	10e. Street and Number	2		10f. Zip Code			Citizen of What Cour	ntry?
	death with the Maryland ms 23a or 28a-f ehow Entust for collified at	Funeral	7903 Delmont Stati	12 Was Decedent Ever	in U.S. 13.	21144 Was Decedent of H	ispanic Origin? (Spe	ecify Yes or No-	J.S.A.	can Indian,
_	be filed within 72 hours after death with the Marylan Hydione. d athydione. d other than "naturel", or Items 23a or 28a-f show event, the Madical Examinar must be codified at	by Fun	1 Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		If Yes, specify Cuba XZYes 2□ No	in, Mexican, Puerto Specify Puert	Rican, etc.)	Black, White, Specify: wh	etc. ite
	72 hou nature		15. Decedent's Edu (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occupa	ation during most of works	16b	. Kind of Business/In	dustry
121	filed within 72 Hygiene. Sther than "na ent, the Madic	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired N/A	0		N/A	
2 2	be filed ttal Hygi d other event, I	Be C	17. Father's Name (First, Middle, Last)			,		(First, Middle, Maid	den Sumame)	
Maryland	Me at c	2	Christian Wolfram 19a, Informant's Name/Relationship (7)		10h Maili	na Address (Street		Morales	ty or Town, State, Zip	Code)
	12 s h ar 7 ts treu		Jessica Morales Wi		1	Delmont				1144
w	Pages 1 end nent of Heelt int: If item 2 iry or other		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ I	Removal from State		matory or other plac	:e)		Location - City or To	
<u>=</u>			4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Euneral Service Licens) W		del Crema 2. Name and Addres		_	denton, M	aryland
Ba	Departi Departi Importi any Inj		163 Styl	/ M007		onaldson 13 Talbot		Home, P.A. Laurel,		20707
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the cone cause on each line.	death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	seguince of:	rallered	7	emlerar		
	Examiner		Sequentially list conditions	. sponton	eous	rester	u & m	embras	real	
	ted nslt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	nsequence of):		U			
o,	The law requires that the death certificate be executed tte has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit		that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):					
68760,	icate b physic s the b	dlcal		d						
Вох	leath certific attending p	an/Me	230. Was decedent pregnant	23c. If yes, outcome of pro		☐Ectopic pregnancy	,		23d. Date of deliv	
O.	the dea / the att ched fo	by Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time 9☐Unknown		Other (specify)			Month	Day Year
ر. ص	res that the de signed by the a i be detached i	y Ph	Part II. Other significant conditions co	intributing to death but no	t resulting in the t	underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to t	
Records,	v require been sig should b							1 Tes	7	bably 4 Unknown
Rec	The law e has t age 2 s	Completed						24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of
		BeC	25. Was case referred to medical examiner?					h (Check only one)	10 103	-
	는 든 표	၉	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatie		4 🗀 Nursing no	me 5 Residence	e 6 Other (Speci	fy)
0 U	ath. or: Alte	atlor	1 Natural 5 Pending investigation	(Month, Day Yea	ar) Injury	Wor	k? Yes 2 □ No			
Division of	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S)		reet, factory, office		28f. Location (Stree City or Town, S	t and Number or Rur tate)	al Route Number,
_	To the Hospital or Attending F within 24 hours efter death. To the Funerel Director: After completely filled in by the funer			ysiciam To the best of my iner: On the basis of exa						
	the Hithin 24 the Formplete	Medical	29b. Signature and title of certifier	and manner stated.	Δ	29c. Licens		100	Data signed (Manch	One Vand
	⊢≱≓ŏ		Man day H	vatson,	MD	0415	598	α	Ng. 29.	,2006
			30. Name and address of person who c	completed cause of death	(tem 23a) (Type	Colum.	kia N	N 210	NG. 29	
	Sta Registi		31. Date filed (Month, Day, Year) SEP 0 7 2006	Registrar's S	Signature do	de	*			
	3		SEP 0 / 2000	, , , , , , , , , , , , , , , , , , , ,	-					

State of Maryland / Department of Health and Mental Hygien 2005

28294

Medical	1	G=R	TROUBE 1	NEST	7		Month	Aug 31, 2006	Year 3	3. Time of Death 6:30 p
aminer		4a. Facility Name (If not institution, gi	ve street and number) 361 Holstein Avenu		4b. City, Town, o	r Location of Dea Gler	th Burnie	4c. County o		rundel
eral ctor	5	5. Social Security Number 6.		yrs. last birthda 84 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hr. Hours Mir	8. Date of Bin (Month, Da May 1	th ly, Year) 1, 192 2	9. Birthp Coun	olace (State or Fore otry) Virginia
adet or	Ī	Usual Residence of Decedent 10a. State 10b. County Maryland Anne	e Arundel	c. City, Town or I		en Burnie				0d. Inside City Lim
Director		10e. Street and Number 7361 Holstein Avenue			10f. Zip Code	21060		10g. Citizen of W	hat Coun	itry?
or other traumatic event, the Madical Examinat must be notified at To Be Completed by Funeral Director	Dy runera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	in U.S. 13	B. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	14. Race Black Specify:	, White,	an Indian, etc. Black
it, the Medical E	ounbiered	15. Decedent's E (Specity only highest gr Elementary/Secondary (0-12)	Education	(Giv	cedent's Usual Occup ve kind of work done . DO NOT use retired	during most of we	orking	16b. Kind of Bus		dustry School Dept.
raumatic event, in To Be Co	ם ו	17. Father's Name (First, Middle, Las.	t) ert Smith			18. Mother's Na		Maiden Sumame)	
r trauma		19a. Informant's Name/Relationship Grace Miller	(Type, Print)		iling Address (Street 1224 Queen A					Code)
any injury or other once.	2	20a. Method of Disposition 1	Removal from State	cemetery, cr	position (Name of rematory or other place Cemetery & N		Date 09/07/06	20c. Location - C		wn, State
any inj		21. Signature of Funeral Service Lice	man Fato		22. Name and Addre	rothers Fun	eral Service Baitimore, Mo	P. A.		
	-	1	111	11					- 1	
ian		23a. Part1. Enter the of ease, or conshock, or heart a ure. List only Immediate Cause (FirM) disease or condition	nplications that caused the y one cause on each line	Hith. Do not e	inter the mode of dy	υch as cardia	c or respiratory ar	rrest,		Approximate Interval Between Onset and Death
cian ical iner		Immediate Cause (FiMI disease or condition resulting in death)	nplications that caused the yone cause on each line a Due to (or as a con	eta>1	115 C	TOSA N	Ç	rrest,		Interval Between
ical transit	LAGIIIIIGI	Immediate Cause (FixI)	_aM	nsequence of):	115 C	TOSA "	Ç	rrest,		Interval Between
or use as the burial-transit and transit a	medical Evalling	Immediate Cause (Find disease or condition resulting in death) Sequentially 1st conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a col	nsequence of): nsequence of): regnancy Fetal death 3	115 C	ncin	Ç	23d. Date Mont		Interval Between Onset and Death
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If director, page 2 should be detached for use as the burial-transit of the Completed by Physician/Medical Examiner		Immediate Cause (Find disease or condition resulting in death) Sequentially 1st conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yys 2 No 27. May er of Death 1 Natural 5 Pending investigation	Due to (or as a condition of the contributing to death but not the contribution of properties of the contribution of the contr	nsequence of): nsequence of): regnancy Fetal death 3 of death 5 of resulting in the	ent 3 DOA Oth	en in Part I. 26. Place of Deer: 4 \(\) Nursing	23a. Did to 1 Yes ath Check only o	23d. Date Mont obacco use contributes 2 \(\text{No} \) No 3 an 24b. W pressy med 2 (5) No 1 (5)	ch boute to the boute to the construction of t	ry Day Year e cause of death? ably 4 Unknown psy findings availal mpletion of cause of 2 No
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etely filled in by the funeral director, page 2 should be detached for use as the burial-transit of color director. To Be Completed by Physician/Medical Examiner		Immediate Cause (Find disease or condition resulting in death) Sequentially 1st conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. May er of Death 1 Natural 5 Pending investigation of the conditions of the condition	Due to (or as a condition of the contributing to death but not the contribution of the	nsequence of): nsequence of): nsequence of): regnancy Fetal death 3 of death 5 of tresulting in the 2 □ ER/Outpatid ar) 28b. Time Injury At home, farm, specify)	ent 3 DOA Oth of 28c, Injur Wor M 1 street, factory, office	en in Part I. 26. Place of Deer: 4 Nursing ly at k? Yes 2 No	23e. Did to 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	23d. Date Mont obsector use contributes 2 No 3 an 24b. What was primed 2 No 1 lone of Other now injury occurrence of Street and Number of No. State)	ere autopior to contact? Yes (Specify d	ry Year The cause of death?
ed in by the funeral director, page 2 should be detached for use as the burial-transit of constant of		Immediate Cause (Find disease or condition resulting in death) Sequentially 1st conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yys 2 No 27. Man er of Death 1 Natural 5 Pending investigations of the conditions of the conditio	Due to (or as a condition of the contributing to death but not building, etc. (S)	nsequence of): nsequence of): nsequence of): regnancy Fetal death 3 of death 5 of tresulting in the 2 □ ER/Outpatid ar) 28b. Time Injury At home, farm, specify)	ent 3 DOA Oth of 28c. Injur Morty street, factory, office	en in Part I. 26. Place of Deer: 4 Nursing ly at k? Yes 2 No	23e. Did to 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	23d. Date Mont obacco use contributes 2 No 3 an 24b. Whise Mont of the contributes of the	ere autopior to contact? Yes (Specify d	ry Day Year e cause of death? ably 4 Unknown osy findings availal impletion of cause of 2 No Route Number,

State of Maryland / Department of Health and Mental Hygiene 200628295 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last)
THERESA WINDISH **Physician** SEPTEMBER 4, 2006 4:30 A M /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE RIVERVIEW NURSING FACILITY **ESSEX** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 9/25/1916 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 89 Months 1 □ M 2 🕱 F Vrs MARYLAND Director 215039737 Usual Residence of Decedent with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Director BALTIMORE ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 or Herns 23e 7219 HILLTOP AVENUE 21237 USA death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 Mo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "natural", or titer any injury or other treumatic event, the Medical Exama 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: by Specify: WHITE 3XXVidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BOLEWICKI FRANCES ZIEMKOWSKI STANISLAUS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE WINDISH JR. /SON 1410 LIBRA STREET MISSION, TEXAS 78572 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐8urial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HOLY REDEEMER CEM 9/7/06 BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Fun Service Licensee 1211 CHESACO AVENUE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, the attending physician 99 Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months Day 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown On Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 100 24a. Was an autopsy performed 2 No 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2√2 No Nursing Home 5 Residence 6 Other (Specify) 2 Pils 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Naturaf 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours at To the Funerel D 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29c. License number D-38754 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D ss of person who completed cause of death (ftem 23a) (Type, Print) BASTERN BLUD. 32 Aegistrar's Signature 31. Date filed (Month, Day, Year) SEP 0 7 State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene? 006 28296 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 0927 AM SEPTEMBER WHITE ELIZA BETH 5, 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE RANDAULSTOWN NORTHWEST HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2XX Months Yrs. 85 **Director** 216-16-5788 September 03,1921 Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be ruillied at 1 Yes 2XXNo Directo Maryland **Baltimore** Pikesville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 808 Templecliff Road 21208 United States of America Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Veterans College (1-4or 5+) Elementary/Secondary (0-12) Volunteer Administration Ith and Mental Hygis 27 is marked other r traumatic event, III 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ould be f Mental h Herman Eichhorn Bertha Brown Pages 1 and 2 should nent of Health and Men 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health a litem 27 is r other tra (Daughter) 96 Ridgelawn Road, Reisterstown, Maryland 21136 Diane Stern 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1207 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department Important: If any injury o 09/08/06 Woodlawn, Maryland Lorraine Park Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Sonatura of Funeral Service permit Loring Byers Funeral Directors colnor Men 337 8728 Liberty Road, Randallstown, Maryland 21133 A Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, (slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hours respiratory /Medical Due to (or as a consequence of **Examiner** hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sepas Due to (or as a nonsequence of): Physician/Medical Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed then be 11200 Due to (or as a consequence of): Box 68760 physician the as attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 SNo Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 9 2 s certificate has 1 Yes 2 No 2 XNo 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 >4 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA 늉 Certification: To 2 ER/Outpatient After the 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funerel Director:,
completely filled in by the t 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, elc. (Specify) 4 Homicide the Hospital 1🕰 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mo D0059736 September 5, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COURT ROAD MORTHWEST HOSP ITAL 00 -0 DEBURAH MCLTAN 5401 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2006 28297 Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician JOYCE SEPT 8: 56 PM WOOD 2006 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Columbia
If Under 1 Year If Under 24 Hrs. Howard County General Hospital Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☐ M 21XF 63 Yrs. May 26, Director 218-52-1961 Maryland 1943 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show ir than "natural", or itema 23a or 28a-f showns the Madical Examinar must be notified at 1 ☐ Yes 2 🕅 No Maryland Howard Director Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 10319 Wilde Lake Terrace 21044 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ₩ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Finance Mortgage Banker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fite Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other treumatic event once. Be John C Jenkins Virginia Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10319 Wilde Lake Terrace, Columbia George Wood/Husband MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sept 5,2006 Catonsville Metro Crematory 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd. Columbia, MD 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician week PNEUMONIA /Medical Due to (or as a consequence of): Examiner CANCER METASMAC LUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Completed by Physician/Medical ed by the attending deteched for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 100 2 🗀 No is after deau...
rel Director: After this co...
in by the funeral director, pe 1☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 ☐ 16 28b. Time of Injury 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D51860 40 SENT 2, 2006 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) 5 16700 CHARREN DRIVE #700 JONATIAN FISH MO 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SFP 0 7 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 28298 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician 3:45AM 29,2006 2013ERT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 6, 1 ARUNDEL BALDIMONE WASHINGTON MEDICAL CENTER Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**™** M 2□ F 213 26 2175 77 Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Iteme 23s or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Baltimore Maryland Anne Arundel Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S. 5406 Park Road 21225 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 数Yes 2 □ No If Yes, Give Year or Dates: Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Deperment of Health and Menial Hygiene. important: if item 27 is marked other than "natural", or Item any injury or other fraumatic event, the Madical Examinat Once. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Machinist Government Contractor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Virginia M. Intrye Eugene M. Welck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21225 Mildred Welck / wife 5406 Park Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 19/2/2006 Baltimore, Maryland Cedar Hill Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signatur you eral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Interval Between Onset and Death Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List entry one cause on each line. 23a. Part . Enter the disease, Immediate Cause (Final disease or condition resulting in death) **Physician** 111-17730Lic AC100555 /Medical Due to (or as a consequence of): Examiner OFHYJILMON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospitel or Attending Physician: The law requires that the death certificate be executed 24 hours eiter death. and Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 □ Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Tes 2 1No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 ☑ No 1 Unpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation etter death. I Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely titled in by 4 Homicide within 24 hours e 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 005370 10.71 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Tsion Berhane 300 Hospital Drive Glen Burnie, Maryland 21061 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician th PAUL 5 SEPTEM BER 2006 WYNDHAM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore N/A Levindale Hebrew Geriatric Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**⊠**M 2□F 236 50 1466 71 Feb. 13, Director 1935 West Virginia Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f ahow treumstic event, the Medical Examiner must be notified at 1 Yes 2X No Director Maryland Baltimore Windsor Mill 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 6 U.S. 4 Rollwin Road 21244 or iteme 23a death Funeral 14. Race - American Indian, Bfack, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married 1 Yes 2 No Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: It Yes, Give Year or Dates: Korean þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Mechanic Maryland Transit Adm. 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Daisy Ruth Fravel John William Wyndham ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other treum once. Windsor Mill, Maryland 21244 4 Rollwin Road Paulette Wyndham / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Cedar Hill Cemetery 9/9/2006 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 romural or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate fnterval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. fmmediate Cause (Final **Physician** CORONARY ALT ARTERY DISEASE 2415 disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto for as a ponsecuance off Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached 9 Unknown 9 Unknown certificate has been signed by t rector, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Monknown SACRAL DECUBITUS Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 Yes 22 No 1 Yes 2 No 1 Yes : After this certification of the sector. It To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Pface of Death (Check only one) Be Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 👺 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number SEPTEMBEN 5th 2006 00054739 Donna M aurily mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Belucdere Avenue Maryland 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State SEP 07 2006 Registrar

State of Maryland / Department of Health and Mental Hygien 2 0 6

For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 1:25P **Physician** 946USI /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Jan. 10, 1913 Montgomery Hebrew Home of Greater Washington 6. Sex 14 M 2 ☐ F 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** 565-09-8955 93 Minnesota Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Directo Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 20852 U. S. A. 6121 Montrose Road Funeral 12. Was Decedent Ever in U.S. Amped Forces? 1 Myes 2 □ No Army If Yes, Give Year or Dates: WW 2 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Technical Writer 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vivian Mitzlowin Elijah Avin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
120 Shelborne Avenue, # 314 Toronto, Ontario,
Canada M6B2M7 19a. Informant's Name/Relationship (Type, Print) Judy N. Fields - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, Virginia King David Mem. Gdns | 8/18/2006 21. Signature of Funeral Service Licenses Edward Sagel Funeral Direction, Inc. Conald 20852 1091 Rockville Pike, Rockville, Maryland 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 2 No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 V Nursing Home 5 TResidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier cause of death (Imm 23a) (Type, P 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Marylan		artmer <i>rtificat</i>				Reg. No.	6 28301
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of De Month	Day _ Y	3. Time of Death
,	/Medic		Bernard Anderman						August		
j	Examin	er	4a. Facility Name (If not institution, give s	treet and number)		Beth		Location of Deatl	1	4c. County of Montgon	
	F		Suburban Hospital 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)		-	If Under 24 Hrs.	8. Date of Bir	th 9	Birthplace (State or Foreign
	Funeral Director			M 2□F 89	Yrs.	Months	Days	Hours Min.	Jan. 1	v. Year)	ew York
	D		Usual Residence of Decedent								
	how	L	10a. State 10b. County	10c. Cit	, Town or Lo	ocation					10d. Inside City Limits
	e Ma	cto	MD Montgomery	7 Che	vy Cha	se					1X Yes 2 □ No
	or 2	Dire	10e. Street and Number				Code			10g. Citizen of Wha	at Country?
	ath v	rai	4601 North Park A		0 1.0	208			7 14	U.S.A.	
	within 72 hours efter death with the Maryland ene. than "naturel", or itema 23e or 28e-f ehow the Madical Examinar must be notified at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	2. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Dece If Yes, spe	dent of His cify Cubar	panic Origin? (S i, Mexican, Puert	pecify Yes or No o Rican, etc.)		American Indian, White, etc.
36	rs eft	by F	3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 No 1942 If Yes, Give 1946	-	1 🗆 Yes	2X No	Specify:		Specify:	Thite
21215-0036	P hou	ed	15. Decedent's Educ	ation	16a. Dece	dent's Usu	al Occupa	tion		16b. Kind of Busin	
212	7 uir 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of wo DO NOT u	ork done di se retired)	uring most of wor	rking		
2	d with	mo:	Elementary (o 12)	5+	Chi	ef of	Spe	ech & He	aring	Veterans	Administration
밀	at Hy Coth	Be	17. Father's Name (First, Middle, Last)						- ,	, Maiden Sumame)	
<u>Ja</u>	Ment Ment Mrked Mrked	To	Arthur Anderman						ie Wei		
a	end end is ma		19a. Informant's Name/Relationship (Type	•						er, City or Town, Sta	
2` 	and ealth m 27		Arthur D. Chotin- I							ton, DC 2	
0	# F H P		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☑ R	amovar nom State	lace of Dispo emetery, crea			ı	Date	20c. Location - Ci	
<u>=</u>	Ta in Pa		4 □ Donation 5 □ Other (Specify)		tional					Falls Chu	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health end Mental Hyglene. Importent: If Item 27 is marked other than *naturel', or Itema 23a or 28a-f ehow any liuly or paper treumatic event, the Mardical Examinar must be notified at ance.	5 %	21. Signature of Funeral Service License	0					_	rial Chap ille, MD	
			23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the death	n. Do not ent	ter the mod	de of dying	, such as cardiad	or respiratory a	rrest,	Approximate Interval Between
Jan 3	Pnysician		Immediate Cause (Final disease or condition	Pneumonia							Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq	uence of):						
	Examiner		Sequentially list conditions, b								
	D #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):						
	ecute and -trans	kam	that initiated events resulting in death) Last	Due to (or as a conseq	uanaa of):						
90	cien burial			Due to (or as a conseq	dence on.						
68760,	icate be executed physicien and s the burial-transit	edical		•							
_			IF FEMALE:	3c. If yes, outcome of pregna	ncv					23d. Date of	of delivery
Box	The law requires that the death certitelending the been signed by the ettending page 2 should be detached for use a	Physician/M	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	death 3	Ectopic p Other (s				Month	,
<u>о</u> .	the d y the	ysi	1 Yes 2 No 9 Unknown	9☐ Unknown		_	,,				
	that hed b	by Pt	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying (ause give	n in Part I.	23e. Did t	obacco use contribu	ute to the cause of death?
Records,	quires t n signe								1 🗆	Yes 2 □ No 3	☐ Probably 4 🛣 Unknown
ဝွ	w require s been sign should b	Completed							24a. Was		re autopsy findings available
Re	he lav e hes age 2	E								ormed? dea	
Vita	en:] tificel tor, p	0	25. Was case referred to medical					26 Place of Dea	1 Tes		Yes 2□ No
<u>=</u>	Attending Physician: The in death. ector: After this certificate he by the funeral director, page	OB	examiner? 1 ☐ Yes 2 🔯 No	ospital:	ER/Outpatier	nt 3 🗆 D0	Othe	r		dence 6 □Other	(Specify)
1 0	g Ph ter th	T:u	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	if :	28c. Injury Work	at ?	28d. Describe	how injury occurred	
<u></u>	ath. rr: Aff	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 1 Sar)	injury	М		es 2 □ No			
Division		ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, sti	reet, factor	y, office		28f. Location (City or To	Street and Number	or Rural Route Number,
ō	rs efter rel Dire	O		3, 11, 12, 20, 11, 12, 12, 12, 12, 12, 12, 12, 12, 12							
	To the Hospital or Attenwithin 24 hours efter deatl To the Funeral Director: completely filled in by the	Medical		ician: To the best of my kno er: On the basis of examina and manner stated.							
	o tha	Me	29b. Signature and title of certifier			29	c. License	number		29d. Date signed (/	Month, Day, Year)
	-350		> ////// a ///				D6294	9		8-18-06	
•	5		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type.						
			Natasha Haag - 8				Bethe	sda, MD	20814		
	Sta		31. Date filed (Month, Day, Year) ASSC 2 3 20	32 Registrar's Signa	ture	antes	4				
	Registr	200	MIG 2 3 20	UUI SOP . O . O . O	10 25	ALE THE PERSON NAMED IN					

Physici	an	1. Decedent's Name (First, Middle, Last) John	Jerry	Adams				Date of De Month	ath Day		Year	3. Time of Death
/Media			rald	Adams					August		7	2006	8:10 p
Examir	ner	4a. Facility Name (If not institution, give 12401–A Old Annap			1		Location o	of Death			Fred		1.
		5. Social Security Number 6. Se		e (In yrs. last b		er 1 Year	If Under 2	24 Hrs.	8. Date of Bir				ace (State or Fore
Funeral Director			T 14 0 0 0 0	55	Yrs. Months		Hours	Min.	(Month, Da	v. Year)		Coun	ington, I
		Usual Residence of Decedent							1145 - 1	_,		abii	
how		10a. State 10b. County		10c. City, To	wn or Location							1	Od. Inside City Lim
- 4	cto	Maryland Frederic	k	N	lt. Airy								1 ☐ Yes 2 🔯
or 28	Dire	10e. Street and Number			10f. Z	ip Code				•	zen of W		•
f Health and Mental Hygiene. Item 27 Ie marked other then "naturel", or Items 23s or 28s-1 show other traumatic event, the Medical Examinat must be notified at	Funeral Director	12401-A Old Anna			40.111 0	217		-:-0.40	-7. 27 11.		ited		tes an Indian,
Items Instrum	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☒ N		If Yes, sp	edent of Hi ecify Cuba	ispanic Origin, Mexican	gin? (Spe , Puerto	cify Yes or No Rican, etc.))-		, White,	
', o	by F	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:	•0	1 ☐ Yes	2 ∑ No	Specify:				Specify:	W	hite
a a	ted	15. Decedent's Ed	ucation	16	a. Decedent's Us	ual Occupa	ation			16b. Ki	nd of Bus	siness/Inc	dustry
We in	pie	(Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5	+)	(Give kind of w life. DO NOT	vork done d use retired	during most I)	t of worki	ng				
giene Transport	Completed	12			Plum	ber					Uni	on	
al Hy	Be (17. Father's Name (First, Middle, Last)							(First, Middle			a)	
and Mental Hygiene. Is marked other then surnatic event, the Ms	Lo	Leroy H. Adams					(Gene	vieve H	allo	ran		
ealth and Mental P n 27 le marked of her traumatic eve		19a. Informant's Name/Relationship (T	ype, Print)		b. Mailing Addre								
Health tem 27 I			Son		1301 Tre		ew Lar	-	Monrovi				21770 wn, State
i of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemet	ery, crematory or	other plac	I		st 23,				
tant: jury		4 □ Donation 5 □ Other (Specify		Frede	rick Cre		-						aryland
Department of Heali Important: If Item 2 eny Injury or other once.		21. Signature of F	See		22. Name 8			DL	auffer d. Mt	Fune . Air	ral cy, M	Home Maryl	s, P.A. and 217
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-				10.			J.	ÇATOIAC C					
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		1 - State Registrar	State of Maryland / Dep	ertificate of	Death	Reg	g. No. 2 U U b	28303
Physi /Med		1. Decedent's Name (First, Middle, Law Wallace E.	Adams			2 Date of Death Month August 1	Day Year	3. Time of Death 6:00 a M
Exam		4a. Facility Name (If not institution, given Alfred House	e street and number)		or Location of Death	1	4c. County of Death	gomery
Funera Directo		5. Social Security Number 6. S 579-12-1542 Usual Residence of Decedent	ex 7. Age (In yrs. last birthda GM 2□F 83 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) June 10,	Year) 9. Birth	nplace (State or Foreign untry) rginia
BAITIMOTE, MATYIANG Z1Z13-UU30 permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28s-f show eny injury or other traumatic event. The Medical Examinar must be notified at	To Be Completed by Funeral Director	3 Widowed 4 Divorced 15. Decedent's Ec (Specify only highest grave specify only highest grave) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last, James Franklin Ac 19a. Informant's Name/Relationship (Betty L. Adams/ 20a. Method of Disposition 1 Burial 2 Occumation 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licer)	12. Was Decedent Ever in U.S. Armed Forces? 1	Spring 10f. Zip Code 10f. Zip Code 1 Was Decedent of Highes, specify Cubic telephone (Comparis Usual Occupies kind of work done). DO NOT use retired the Repression (Name of tematory or other planatory or other planatory and Address (Street telephone).	specify: pation during most of wor d) sentative 18. Mother's Nan Jettie and Number or Ru dje Road, ce) Aug 2 seofiatiliths	pecify Yes or No- o Rican, etc.) king ne (First, Middle, Ma Lee Child ral Route Number, (Silver S Date ust 18, 006 Funeral H	aiden Sumame) Iress City or Town, State, Z Iring, MD Oc. Location - City or	A rican Indian, o, etc. te ndustry r Company ip Code) 20906 Town, State
Physiciar /Medica Examine		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. Do not e	nter the mode of dyir				Approximate Interval Between Onset and Death 2 Years Years
DOX DG/ON sath certificate be attending physicis for use as the bur	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		5.6 □ Ectopic pregnancs □ Other (specify)	y		23d. Date of deli Month	Years
II RECOIDS, P.O. The law requires thet the de are has been signed by the page 2 should be detached	Completed by Ph	Immobility Post	contributing to death but not resulting in the cural Hypotension	underlying cause giv	ven in Part I.	1 ☐ Yes 24a. Was an autopsy performe	24b. Were au prior to death?	obably 4 Munknown topsy findings available completion of cause of
OT VICAL IN Physician: The this certificate h ral director, page	To Be Co	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati		er: 4 ☐ Nursing H		ce 6 1 Other (Spec	2□No Waroup Home
SION anding sath. or: After	Certification:	27. Manner of Death 1 XSNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	8 290 Place of Joines, At home form	M 1	y at k? Yes 2 ⊡ No	28f. Location (Stre City or Town,	et and Number or Ru	ral Route Number,
To the Hospitel or Atti within 24 hours after de To the Funeral Direct	Medical	(Check only 2 Medical Example)	ysician: To the best of my knowledge, de niner: On the basis of examination and/or and manner stated.	ath occurred at the fir investigation, in my o	ppinion, death occu	rred at the time, date	e and place, and due	to the cause(s)
T With		29b. Signature and title of certifier	(Queess m)	D254			d. Date signed (Month	
(x)00	tate	30. Name and address of person who Oliver Lawless, 31. Date filed (Month, Day, Year)	32 Aegistrar's Signature		ve, Olne	y, MD 208	32	

			For State Registrar	State	of Maryl		partment of Certificate of		nd Mental Hy	giene Reg. No.	2006	28304
			1. Decedent's Name (First, Middle	e, Last)					2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia Medic		Christian J	ohn	Achste	tter			August		006	2:50 p M
	Examin		4a. Facility Name (If not institution			alatata.	4b. City, Town,	or Location of C			ounty of Deal	th
			14805 Pennfield	d Circle.	Apt.	204	Sil	ver Spr	ing	r	Montgor	mery
	Funeral		5. Social Security Number	6. Sex		yrs. last birtho	(ay) If Under 1 Yea		Hrs. 8. Date of Bi	rth	9. Birt	thplace (State or Foreign
	Director		579-22-9197	1 ☆ M 2□F	91	Yrs	Months Days	s Hours	Dec. 7			shington, DC
	<u>D</u>		Usual Residence of Decedent									
	nylar how	.	10a. State 10b. County		100	. City, Town o	r Location					10d. fnside City Limits
	a-fs	5	Maryland Mon	gomery		Silve	r Spring					1 ☐ Yes 2 ☐ No
	n th	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Co	ountry?
	23a		14805 Pennfi	eld Circl	e, Apt	. 204		20906			USA	
	dea	Funerai	11. Marital Status	12. Was De Armed F	cedent Ever	in U.S.	13. Was Decedent of	Hispanic Origin	? (Specify Yes or N Puerto Rican, etc.)	0- 14	I. Race - Ame Black, Whit	
9	or it		1 ☐ Never Married 2 Married		2 🗆 No		1 ☐ Yes 2 ☑ N		, , , , , , , , , , , , , , , , , , , ,		Specify: Wh	
g	ural',	d by	3 Widowed 4 Divorced	Year or	Dates: 194							
21215-0036	72 h	ete	15. Deceden (Specify only highe		()	(0	ecedent's Usual Occ live kind of work don	e during most of	f working	16b. Kind	d of Business	Industry
<u> </u>	Althin	Completed	Elementary/Secondary (0-12)		(1-4or 5+)	111	fe. DO NOT use retii	rea)		- .		
N	filed within 72 hours efter death with the Maryland Hygiene. ther then "natural", or fleme 23a or 28a-f show that the Medical Examinal must be notified at		17. Father's Name (First, Middle,	5+			Attorney	10 Mothada	Name (First, Middle			evenue Servic
Maryland	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mentel Hygiene. Important: If Item 27 Is marked other than "natural", or Itema 23a or 28a-f show any Injury or other traumatic event, the Medical Examination at any Injury or other traumatic event, the Medical Examination at any Injury.	Be			tor				herine I.		-	
3	Mer Merker Marker	၉	Charles George		CET	101.1						T. 0. 4.1
Jai	2 sh and lan		19a. Informant's Name/Relations	hip (Type, Pnnt)		19b. M	lailing Address (Stree	et and Number o	or Hurai Houte Numi	oer, City or	Iown, State, A	Zip Code) 20906
di.	and fealth m 27		Estelle Achste	tter/ Wif			05 Pennfi isposition (Name of	eld Cir	cle. Apt.		Silver ation - City or	Spring, MD
Ö	t of t		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from	n State	cemetery,	crematory or other p	At	igust 22,	200. 100	ation - City of	TOWIT, State
Baltimore,	men tent: jury		4 Donation 5 Other (S				Heaven Cemet	ery	2006			ing, Maryland
3a	Deparit		21. Signature of Funeral Service	Licensee			Ffancis Af	resset Figure	ns Funera	1 Home	e Inc.	
_	205 g g		y. hen Stil	20			500 Unive				Spring	
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the each line.	death. Do not	enter the mode of d	ying, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between
1	Physician		tmmediate Cause (Finaf disease or condition	avbA .	nced ('ongest	ive Heart	Failur	e			Onset and Death
	/Medical		resulting in death)	Due to	o (or as a cor	nsequence of)						
	Examiner		Sequentially list conditions,	Chro	nic Ok	struct	ive Pulmo	nary Di	sease			
	ם ב	ner	if any, feading to immediate cause. Enter Underlying	Due to	o (or as a cor	nsequence of)						
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မ	ing p	Mec	IF FEMALE:			73.5						
Вох	tend tend	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, o	utcome of pr		3 □Ectopic pregnar	ісу		23	3d. Date of de Month	fivery Day Year
Э. П	The law requires that the death certificate has been signed by the ettending Is age 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No	4□Pre	gnant at time mown	of death	5 ☐ Other (specify)				Wichti	Day Toal
P.O.	at th	P.	9 Unknown			. 10' ' 11			00 - Did			
	igner bed	Ď	Part II. Other significant conditi	ons contributing to	death but no	t resulting in tr	ie underlying cause (given in Parti.				o the cause of death?
ord	w requires to been signer should be a	ted							_	1105 2	INO SULF	TODADIY 4 GOIRIOWII
Vital Records,	law r as be 2 sh	Completed							24a. Wa auto	s an opsy	24b. Were at	utopsy findings available completion of cause of
Œ	The I	Š								ormed? 2 ⊠ No	death? 1 ☐ Yes	2 □ No
ita	ysicien: Th is certificete director, pag	Be	25. Was case referred to medica examiner?	1				26. Place of	f Death (Check only	one)		
>	> ∞ 5	T0 E	1 ☐ Yes 2 ☒ No	Hospital: 1	fnpatient	2 ER/Outpa	atient 3 DOA	Other: 4 🗆 Nursi	ing Home 5X Res	idence 6	Other (Spe	icify)
0	ng Pt ter th	Ë	27. Manner of Death 1 X Natural 5 ☐ Pendi		e of Injury onth, Day Yea	28b. Tim Inju	e of 28c. In	ury at lork?	28d. Describe			
<u>ō</u>	Attending r death. ector: After by the fune	atic	2 ☐ Accident invest	gation				□Yes 2□No				
Division of	or Attendation of the order of the order of the order	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	pined 289. Plac	ce of fnjury -		, street, factory, offic	е		(Street and own, State)	Number or R	ural Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Se										
	Hospital 24 hours a Funeral letely filled	edicai					leath occurred at the					
	To the h within 24 To the F complete	led	one)	and ma	nner stated.				1			``
	To To	Σ	29b. Signature and title of certifie			4.0	29c. Lice	nse number			signed (Mont	
m	8		1	1	, a	D	D6	1696		Augus	st 21,	2006
OX)na-		30. Name and address of person Sharon Yang,				rpe, Print) World B1	vd, Sil	ver Sprin	g, MD	20906	(1)
4	0		31. Date filed (Month, Day, Year	1 22	D. Sietrar'e	Signature			•			
	Sta Registr		AUG 2	2 2006	Elecus	K	Speck					
							The state of the s					

			1 - For State Registrar	State o	of Marylan		artment of tificate o		and Me		jiene 2	006	28305
П	-		1. Decedent's Name (First, Middle, L	ast)					2	2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medio		Harry Edward	Baron						August		2006	8:58A M
	Examin		4a. Facility Name (If not institution, g				4b. City, Town					ounty of Death	
			Brooke Grove Nu			(Spring ar If Under				ntgomen	
	Funeral Director			Sex 1⊠M 2□F	7. Age (In yrs.) 94	Yrs.	Months Day		Min. 2	3. Date of Birth (Month, Pay 2-12-19	$1^{\frac{1}{2}}$		nplace (State or Foreign intry) Land
-	_		579-05-8128 Usual Residence of Decedent									101	Lanu
	how		10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	Ba-1-	cto		gomery	Silv	er Spi	ing						1½ Yes 2 □ No
	h with th	al Director	3111 Farnborough	Ct.			10f. Zip Code 20906				U.S.	n of What Cou A .	untry?
٥	be filed within 72 hours after deeth with the Maryland Hygiene. d other than "natural", or iteme 23a or 28a-f show event, I'm Medical Exotra are must be notified at	Funeral	11. Marital Status 1 Never Married 2 Married	Armed F	2 No		Vas Decedent of Yes, specify C			rfy Yes or No- ican, etc.)	1	Race - Amer Black, White	, etc.
2	aral',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or E	Dates:		10 163 201	о эрвспу.			3)	pecify:Whi	te
7	"nati	Completed	15. Decedent's (Specify only highest g)	(Give	lent's Usual Occ kind of work dor DO NOT use ret	ne durina most	t of working	7	16b. Kind	of Business/I	ndustry
7	withiy ene. then	μc	Elementary/Secondary (0-12)	College ((1-4or 5+)	Merch		160)			Gro	cer	
<u> </u>	e filed wal Hygier I other the	Be Co	17. Father's Name (First, Middle, Las			1101.011		18. Mothe	er's Name (First, Middle,			
Maryiand 21215-0036	ould be Mental Parked Patic ev	To B	Jacob Baron							rutsky			
	es 1 and 2 should be fi of Health and Mental H f item 27 is marked out ir other traumatic ever		19a. Informant's Name/Relationship David W. Baron			308 F	g Address (Stre lamlet (ircle					ip Code)
saitimore,	Pages 1 nent of He int: If item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3: 4 ☐ Donation 5 ☐ Other (Spec		State		sition (Name of natory or other p d Memor	0	-20-0		20c. Loca Falls	tion - City or 1 Churc	Town, State h, VA
Ball	permit. Pages 1 Department of H Important: If its eny injury or ot ance.		21. Signature of Funeral Service Lic	ensee			D апазапа 1170 Ro						0852
			23a. Part1. Enter the dispase, or co shock, or heart failure: List on	mplications that	caused the death	n. Do not ente	er the mode of d	lying, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
	nysician		Immediate Cause (Final disease or condition		Renal I	nsuffi	ciency						Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a consequ	uence of):							
	LXammer	L	Sequentially list conditions,	b	Hyperte								
	ted nsit	nine	if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequ	derice or,							
	arecu al-tra	Examiner	that initiated events resulting in death) Last	c Due to	(or as a consequ	uence of):							
8/PD	cate be executed physician and the burial-transit	dicai		d									
Q Q	tificat ig phy as th											American	
, BOX	at the death certifics by the ettending phatached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live	atcome of pregna birth 2 Fetal mant at time of de	death 3	Ectopic pregnal Other (specify)				236	d. Date of deli Month	very Day Year
r Ö	at the d by ti etach	Phy	9 Unknown			die e ie the un	ded in a second	alana la Dadil		220 Did to	.	anatahuta ta	the serves of death?
rds,	w requires that the been signed by the should be detache	ρ	Part II. Other significant conditions Coronary Arter			uting in the ur	derlying cause	given in Part I.					the cause of death?
ပ္က	- 0.75	Completed	Cardiomyopathy							24a. Was a		24b. Were aut	topsy findings available ompletion of cause of
ř	The ate h page	Š								perfor	med?	death?	25. No
<u> </u>	ysicien: The law us certificate has l director, page 2 s	Be	25. Was case referred to medical examiner?							Check only o			
0	Physicien: this certific ral director,	2	1 ☐ Yes 2 ☒ No 27. Manner of Death		Inpatient 2	ER/Outpatien 28b. Time of	t 3 DOA	Other: 4 Nu					ufy)
	D 9 9	ation	1 ⊠Natural 5 ☐ Pending 2 ☐ Accidentinvestigati	on	of Injury nth, Day Year)	Injury	V	vork? ☐Yes 2☐1		ld. Describe h	ow injury o	ccurred	
=	P Ste	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	, 28e. Plac	e of Injury - At ho ding, etc. (Specif	ome, farm, str	eet, factory, office	Se Se	28	f. Location (S City or Tow	treet and I n, State)	Number or Ru	ral Route Number,
	9 T T T Y	edicai (aminer: On the t	e best of my kno basis of examina nner stated.								
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Lice	ense number			29d. Date :	signed (Month	, Day, Year)
	11/		1 Bright	n	D		D23	958			8-17	- 06	
			30. Name and address of person wh										
			Burt I. Feldman,					vd. Sil	lver S	Spring,	MD 2	20906	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 3	2006	Registrar's Signa	. Spa	well						

		1 - For Stata Registrar	State of Marylan		artment of H tificate of L			iene _{sg. No.} 2006	28306
Dhyeie	ion	Decedent's Name (First, Middle, Last)					Date of Deat Month	h Day Year	3. Time of Death
Physic /Med		DONNA	MARIE	BROOK	S		Aug	19, 2006	
Exami		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County of Dea	ıth
		Shady Grove H				ville	T	Montgo	mery
Funera		5. Social Security Number 6. Sex	111 253 25	last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
Director	r	Usual Residence of Decedent	52	113.			Sept 1	8,1953	New York
and		1.00	10c. Cit	y, Town or Lo	cation	<u> </u>			10d. Inside City Limits
ith the Marylan or 28a-1 ehow	ŏ	Md Montgo	norv	Cai	+horahu:	m.cr			1₽Yes 2□No
the 288	5	10e. Street and Number	пету	Gal	thersbu:	<u>r</u> g	1	0g. Citizen of What C	ountry?
3a or	0	18034 Fence	Post Court		208	77		U.S.A.	
death ma 2	Jera	11. Marital Status	12. Was Decedent Ever in U.	.S. 13. \	Vas Decedent of Hi f Yes, specify Cuba		ecify Yes or No-	14. Race - Am	
a le c	큔	1 Never Married 2 Married	Armed Forces?	1	rves, specify Cuba I∐ Yes 2/⊡ No		Hican, etc.)	Black, Whi	te, etc.
iled within 72 hours after death with the Maryland Hygiene. Hygiene "netural", or Itema 23a or 28a-1 show out, the Worlded Exami are must be notified.	1 by	3 Widowed 4 Divorced	If Yes, Give Year or Dates 1981-	1987	Les STV	эрвиту.		Specify: B	lack
72 h	etec	15. Decedent's Educ (Specify only highest grade	cation	16a. Deced	lent's Usual Occupa	turing most of work	ing	16b. Kind of Business	/Industry
dishin and and and and and and and and and an	ğ	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired	,		Montq. H	ocnico
ygier ygier tr	ဒ	47 February Wind Middle Look	2 Yrs	Pati	ent Acco	Duntant 18. Mother's Nam	veb.		Osbrce
tal H	Be	17. Father's Name (First, Middle, Last)	. 1						
y or	2	Harold J. Ans	stey	105 14-11-	Address (Change	Maxine	e Smit	h City of Four State	Zin Cada)
VICE ST Nanc Nanc Tien		19a. Informant's Name/Relationship (Type) William E. Broo	^{36, Phill)} Husban	196. Mailir	ng Address (Street a	and Number or Hur	al Houle Number	City or Town, State,	20877
T and teelth	1	20a. Method of Disposition			sition (Name of			thersbur	
2 2 2 2 2		1 Surial 2 Cremation 3 R	emoval from State	emetery, cren	natory`or other plac	θ)			
Deficiency or once.		2/ Signature of Funeral Source Living	/A.		ils Cem.		0/06	Germanto	wn, Ma
paritificates, invary facility A. I.A. 1.2-10000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heelth and Mental Hygiene. Importent: If item 27 is marked other than "netural", or itema 23a or 28s-1 show eny injury or other traumatic event, tra Madical Examinar must be notified.		J. Signature of Pulleral State of Care	lowelle	1/2	nowden	[Funera]	Home	P.A. 208 Rockvil	50
		23a. Part1. Enter the disease or compli	cations that caused the deat	h Do not ent	246 N. V	Vashingt	on St,	Rockvil	Le, Md Approximate
		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.						Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	METASTAT		N SMALL	CELL LU	ING CAN	CER	
Examiner			Due to (or as a conseq	luence of):					
	io io	Sequentially list conditions, if any leading to immediate	Due to (or as a conseq	juence of):					
nsit	nin.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
sxecu n and al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	(uence of):					
icate be executed physician and sthe burial-transit	Cal		1						
law requires thet the death certificate be executed as been signed by the ettending physician and 2 should be detached for use as the burial-transit		250							
ondin use a	2	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregna		Tetopia aromana			23d. Date of de	
death deette	icia	in the past 12 months? 1 ☐ Yes 2 ☐ ₩o	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d]Ectopic pregnancy] Other (specify)			Month	Day Year
by th	Physician/Med	9 Unknown	9□ Unknown					1	E1- 250
wrequires thet the death certificate been signed by the ettending phe should be detached for use as t	by P	Part II. Other significant conditions cor	tributing to death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
requires leen signe hould be	ed						1 🗆 Y	es 2⊡No 3⊠XF	robably 4 Unknown
aw re	pieted						24a. Was a		utopsy findings available completion of cause of
E 2 4 8	틍						perfori		_
IVISION OF VITAL F Attending Physician: The ar death. rector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical				26. Place of Deal			
OI VILA Physician: rthis certific ral director,	2	examiner? 1 ☐ Yes 2 ∑tNo	lospital: 1 Impatient 2 I	ER/Outpatier	t 3□ DOA Oth	er: 4 Nursing Ho	ome 5 Reside	ence 6 Other (Spe	ecify)
n Ol ng Phy Iter thii neral o	Ë	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Wor	/ at k?	28d. Describe ho	ow injury occurred	
VISION Attending ar death. ector: After by the fune	ati	2 ☐ Accident investigation			M 1 🗆	Yes 2 □No			
r Att	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str fy)	eet, factory, office		28f. Location (Si City or Town	treet and Number or F n, State)	Rural Route Number,
ral D	ျပ		<u> </u>	-					
Hosp 24 hor Fund etely fi	edical		sician: To the best of my kno ner: On the basis of examina and manner stated.						
UIVISIO To the Hospitel or Attendin within 24 hours after death. To the Funeral Director: At	₹	29b. Signature and title of certifier	9		29c. Licens	e number	2	9d. Date signed (Mor	nth, Day, Year)
10		1 - 14-8	~ ~	10	D-3	5635		Aug 19,	2006
		30. Name and address of person who	·		•				
		Dr Joseph Kap	lan M.D. 18	3111 F	rince P	hillip,	Dr, Oli	ney, Md	20832
S Regis	itate strar	31. Date filed (Month, Day, Year) AUG 2 3 20	32 legistrar's Signa	B. Ap	all				

		_	For State Registrar	State of Mar	-	Departme Certifica			d Mental H	ygiene Reg. Ne	2006	28307
	Dhysinis		1. Decedent's Name (First, Middle, Last)						2. Date of D Month	Da		3. Time of Death
	Physicia /Medic	al -		Rhoda BA	LLAN						2006 County of Death	11:01 A ^M
ı	Examin	er	4a. Facility Name (If not institution, give: Hyatt Classic Adu		100	1	y Town, or Loc vy Cha		eatn		font gomen	• 77
	Funeral		5. Social Security Number 6. Sec		In yrs. last bir.	thday) If Und	r 1 Year If	Under 24 H	rs. 8. Date of E	lirth		olace (State or Foreign ontry)
	Director		122-14-2748	M 200F	82	Yrs. Months	Days H	Hours IV	Jan. 9) 192	24 Nev	y York
	D ,		Usual Residence of Decedent 10a. State 10b. County	1	Ioc. City, Tow	n or Location						10d. Inside City Limits
	fanyia shov	5										1 □ Yes 2 🛣 No
	the A	Director	New York Ulster 10e. Street and Number		ETT	enville 10f. Z	ip Code			10g. Cit	izen of What Cou	ntry?
	n with		1 Clair Court				12428			Unit	ed State	es
	deat ms 2	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was Dec	edent of Hispa	anic Origin? Mexican, Pu	(Specify Yes or Nuerto Rican, etc.)	NO-	14. Race - Ameri Black, White	
36	or Ite	by Fu	1 Never Married 2 Married	1 □ Yes 2 🕅 No If Yes, Give				Specify:	,		Specify: whit	
ő	filed within 72 hours after death with the Maryland Hygiene. Hygiene than "naturel", or Items 23a or 28a-f show she, the Medical Examinar must be troitfied at		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:	16a	Decedent's Us	ual Occupatio	n		16b. K	ind of Business/Ir	dustry
7	in 72 n "na Acolic	plet	(Specify only highest grad			(Give kind of w life. DO NOT	ork done duri use retired)	ng most of	working			,
212	d with giene ar tha	Completed	Elementary/Secondary (0-12)	College (1-401 5+)		Homemak					Own Home	
Baltimore, Maryland 21215-0036	d oth	Be	17. Father's Name (First, Middle, Last)				18		Name (First, Midd		Sumame)	
<u>y</u> la	Men Man Marke Matic	9	William Ta		105	Mailian Adden	- /Street and		a Silber		or Town State 7	Code)
Mai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "naturel; or teams 23a or 28e-1 show eny injury or other treumatic event, the Medical Examinar must be institled at once.		19a. Informant's Name/Relationship (T) Alex Ballan, Hust						r Rural Route Num ville, N		2428	CQue)
ē,	tem 2		20a. Method of Disposition		20b. Place of	f Disposition (N	ame of	1	Date	20c. L	ocation - City or T	own, State
OE.	nt: F		1 XBurial 2 ☐ Cremation 3 X F 1 Other (Specify)			. Israel		ery	8-23-06	Wawa	rsing, N	1 X
alti	partm porte y inju	Ì	21. Si nature di Fur ral Tru Linno	00		22. Name	and Address of		w Funera	1 Hon	16	
<u> </u>	89 = 28		90		_	254 0	arrol1	St.	NW. Was	hingt		20012
			23a. Fart. Enter the disease, or compleshock, or heart failure. List only o	lications that caused the ne cause on each line	ne death. Do	not enter the me	ode of dying, s	such as car	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
E	Physician	7 4	Immediate Cause (Final disease or condition resulting in death)	a		iver Ca	ncer					Months
	/Medical Examiner		resulting in dealth)	Due to (or as a	consequence	of):						
	社学	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence	of):					-	
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.								
Ö,	icate be executed physician and s the burial-transit	Exe	resulting in death) Last	Due to (or as a	consequence	of):						
8760,	ate be	dlcal	(d								
9 xo	The law requires that the death certific tie has been signed by the attending p page 2 should be detached for use as i	/Me	IF FEMALE:	23c. If yes, outcome of	fpregnancy						23d. Date of deliv	env
Bo	atten for u	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death	3 □Ectopic 5 □ Other (Month	Day Year
0	that the de led by the a detached f	hysi	9 Unknown	9□ Unknown								
ď.	res thai igned b	ру Р	Part II. Other significant conditions co	ntributing to death but	not resulting i	n the underlying	cause given i	in Part I.				the cause of death?
Ş	w require been sig should b	ted							_ 1[Yes 2	. □No 3 □ Pro	bably 4 X Unknown
Records,	e law r has be je 2 sh	Completed							24a. W	topsy	prior to co	opsy findings available ompletion of cause of
E .	: The cate h	Con							1 ☐ Yes	rformed? 2∑No	death?	2 No
Vita	Physicien: r this certific ral director,	Ве	25. Was case referred to medical examiner?	Hospital:					Death (Check onl		a FBOIL 10	
o	Phys r this sral di	: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b.	Time of	28c. Injury at		28d. Describ			Assisted Living
on	nding th. :: Afte e fune	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury M	Work? 1 ☐ Yes	s 2 🗆 No				LIVING
Division of Vital	r Attendi er death. rector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury	y - At home, fa	arm, street, fact	ory, office			(Street a. Fown, Stat	nd Number or Rui e)	ral Route Number,
	ital or A irs after rel Direc iled in by											
	Hosp 24 hou Fune Fune itely fil	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	rsician: To the best of iner: On the basis of e and manner state	examination ar	e, death occurrend/or investigation	d at the time, on, in my opini	date and p ion, death o	lace, and due to the control of the time time.	ne cause(s e, date an	and manner as d place, and due	stated. to the cause(s)
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Mec	29b. Signature and title of certifier	D D		2	9c. License n	umber		29d. Da	ate signed (Month	Day, Year)
)	A		* Kaluan	. K. to	li.		D19.	609	1	X	.21.0	1006
	6		30. Name and address of person who c	ompleted cause of dea	ath (Item 23a)	(Type, Print)	- ((
			Raman R. Tuli, M.			stown Ro	ad, Su	ite 2	02, Gait	hers	ourg, MD	20878
			31. Date filed (Month, Day, Year)			Spelle						

			1 - For State Registrar	State of	f Marylan		artment of H		nd Mei			006	28308
	Dhysisi	20	1. Decedent's Name (First, Middle, La	st)					2.	Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medio		Walter Elias Blan							lugust	32	2001	
	Examir	er	4a. Fecility Name (If not institution, giv				4b. City, Town, or			,	4c. C	County of Deat	
		_	Washington County 5. Social Security Number 6. S		7. Age (In yrs.	last hirthday	Hage	rstown		Date of Birt	<u> </u>	Washi	ngton hplace (State or Foreign
н	Funeral Director			M 2□F	65		Months Days		Min.	Date of Birti (Month, Day DV. 26	, Year) 194	0 Wes	u <i>ntry)</i> t Virginia
			Usual Residence of Decedent							. 20	, 101	0 11.00	· VIIgIIII
	how		10a. State 10b. County West		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	Se-1-	cto	Virginia Berkele	у	Ma	rtins	ourg						1 ☐ Yes 2 🛣 No
	ith th	Director	10e. Street and Number 14 Isadore Lane				10f. Zip Code	5404			10g. Citize	en of Whal Co	untry?
	e 23e	ral		10 W D	dian Process in 11	0 10			0 (04			d Stat	
_	item item	Funeral	11. Marital Status 1 ☐ Never Married 2 反 Married	Armed For		5. 13.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, F	Puerto Ric	an, etc.)	` '`	4. Flace - Ame Black, Whit	
20	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	θ -		1 ☐ Yes 2 🙀 No	Specify:			5	Specify: Wh	ite
9500-6121	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "netural", or iteme 23a or 28e-f show event, the Medical Exam are much the collised at	Completed	15. Decedent's Education (Specify only highest gra	ducation			dent's Usual Occupa		Lworking		16b. Kin	d of Business/	Industry
7	Thin We	npie	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use retired,)	Working				
	filed w Hygier other th		12 17. Father's Name (First, Middle, Last,			Land	scaper	40 14-15-1	N			ticult	ure
and		Be						Edith		First, Middle,	Maiden S	umame)	
Ž	d 2 should be f th and Mental H 7 is marked of treumatic eve	ဥ	Willis Blankenshi 19a. Informant's Name/Relationship (-		19h Maili	ng Address (Street a				r City or	Town State	Zin Code)
Baitimore, Maryland 2	D = 1		Jean Blankenship				adore Lan						
ō,	is 1 and of Healt item 2 other		20a. Method of Disposition	, , , , , , , , , , , , , , , , , , , ,	1 0	lace of Dispo	sition (Name of matory or other place		Date 1gust	-		ation - City or	Town, State
Ë	permit. Pages 1 Department of H Importent: If Ite ony Injury or ot		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		state	•	Cremator		200 200		rede	rick.	Maryland
<u>=</u>	partm porte y Inju		21. Signature of Properal Service Licer	1500			Name and Address Sthaven F	_ ,		_			
מ	89729		1/16				01 Catoct						
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ca	aused the death ach line.	n. Do not en	er the mode of dying	g, such as ca	rdiac or re	espiratory ar	rest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	a J1	iterice.	nela	1 Deed	(, ~	1655	Le			Onset and Death
	/Medical Examiner		resulling in death)	Due to (or as a conseq	uence of):		120					
		e	Sequentially list conditions,	b. Due to (or as a consequ	uence of):							
	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	540 10 (or 43 4 001130q	201100 01).							
	be executed sician and burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):							
2/PC	ate be executed hysician and the burial-transi	dicai		d									
Õ	certifica nding ph use as th		IF FEMALE:										
X Q Q	death certifica e attending ph ed for use as t	cian/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outo	rth 2 Teta		Ectopic pregnancy				23	ld. Date of del Month	very Day Year
j	0 00 0	sic	1 Yes 2 No	4☐ Pregna 9☐ Unkno	ant at time of down	eath 5	Other (specify)					Wichan	Day Tour
7.	requires that the de een signed by the a hould be detached f	Physi	Part II. Other significant conditions of	ontributing to de	ath bul not resi	ulting in the u	nderlying cause give	en in Part I.		23e. Did to	bacco us	e contribute to	the cause of death?
g,	uires sign	d by	•				, , , , , , , , ,			1 🗆 Y	es 2 🗆	No 3□Pr	obably 4. Unknown
ecord	v req beer shou	iete						-	_	24a. Was	an	24b Were au	topsy findings available
Ï	0 5 0	Completed							_	autop perfor	med?	prior to death?	completion of cause of
Vitai	iician: Th certificate rector, pag	0	25. Was case referred to medical					26. Place of	f Death (C	1 ☐ Yes Check only o	20 No	1 ☐ Yes	2 No
>	ysici lis cer direc	To B	examiner? 1 Yes 2 No	Hospital:	patient 2	ER/Outpatier	nt 3 DOA Othe					Other (Spe	cify)
0	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of	of Injury h, Day Year)	28b. Time o Injury	f 28c. Injury Work			d. Describe h			
<u> </u>	tendi Jeath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not b					res 2□No					
UIVISION	or At	Certification:	4 Homicide determined	28e. Place	of Injury - At ho ng, etc. (Specify		reet, factory, office		28f.	City or Tow		Number or Ru	ral Route Number,
	Hospital		29a. Certifier 1 Certifying Ph	vsician: To the	best of my kno	wledge, deat	h occurred at the tim	e. date and r	place and	due to the o	ause/s) a	nd manner as	stated
	To the Hospital or At within 24 hours after of To the Funeral Dirac completely filled in by	edicai	(Check only 2 Medical Examone)	niner: On the ba and mann	sis of examina	tion and/or in	vestigation, in my op	oinion, death	occurred	at the time, o	date and p	lace, and due	to the cause(s)
	To the within 2 To the complet	Š	29b. Signature and title of certifier				29c. License	number		1	29d. Date	signed (Monti	n, Day, Year)
	6		17mP.	Un			100	050	81	3	8/2	22106	
	ソ		30. Name and address of person who	completed cause	e of death (Item			10	I .			Δ.Δ	7.54
			31. Date filed (Month, Day, Year)	1 32 B	istrar's Signa	tures.	n Mayh	1 Pen	hy	Hegy	trun	UMI	21740
	Sta Registr		AUG 2 5	2006	Educ	J. A	goods!						

Please Type or Print in Black Indelible Ink

Physici	an/	State of Maryland / Department of Health and Mental Hygiene 1. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 1. Decedent's Name (First, Middle, Last)
dical Exami		Scott Carroll Boward August 20, 2006 1404 hrs
		4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington
Funeral Director		5. Social Security Number Unknown 6. Sex 1. Age (In yrs. last birthday) 1. M 2. F 4.4 Yrs. 7. Age (In yrs. last birthday) 4.4 Yrs. 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State or Foreign Country) Maryland
ow any	ŀ	Usual Residence of Decedent 10a. State
Aaryland 28a-f show 1 at once.	S S	Maryland Washington Hagerstown 10e. Street and Number Unknown 10f. Zip Code Unknown 10g. Citizen of What Country?
with the Maryland ns 23a or 28a-f sho oe notified at once.	I Director	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygerian and Therefore I filed the I and Mental Hygerian (I filed The Tris marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
after d	by Fu	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: White
hours afte "natural", Examiner	ted 1	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
036 ithin 72 ne. r than	Completed	Polisher Musical Instrument
5-0C filed wif Hygien d other the M		
2121 uld be fil Mental P marked c event,	To Be	Wayne Carroll Boward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
t, MD 2121 and 2 should be fit ealth and Mental tem 27 is marked traumatic event,	-	Wayne Carroll Boward / Father 123 Randolf Ave Hagerstown Maryland 21740
ore, ML s I and 2 s of Health au If item 27 ter traums		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Montal Hygene. Important: If tiem 27 is marked other than injury or other traumatic event, the Medica		Smithsburg Crematory 8/24/2006 Smithsburg, Maryland
Balt permit Departi Importi		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a Atherosclerotic Cardiovascular Disease Death
		or condition resulting in death) Due to (or as a consequence of):
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause
-	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
ecuted and transi	alE	d.
60, ate be ex hysician e burial	Medical	UNPENDED AMENDED IF FEMALE. 23c. If yes, outcome of pregnancy 23d. Date of delivery
	an/N	23b. Was decedent pregnant in the past 12 months? 25c. If yes, butcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
	Physician/	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify)
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ord: aw requas been as been 2 shoul	Completed	24a Was an 24b. Were autopsy findings available autopsy performed? death?
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of Vital Recong Physician: The law		1 Natural 5 Pending 2 Accident Investigation
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Division of Vita at or Attending Physician s after death at Director: After this cered in by the funeral directs		3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division of Vital Records, P.O. Hospital or Attending Physician: The law requires that the 2st hours after death tuneral Director. After this certificate has been signed by telly filled in by the funeral director, page 2 should be deach	Certification:	
Hospi 24 hou Funer tely fil	Certification:	
Division of Vita To the Hospital or Attending Physician within 24 hours after deanth are the Funeral Director. After this cer completely filled in by the funeral direct		Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
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Division of Vita To the Hospital or Attending Physician within 24 hours after death To the Funeral Director. After this cer completely filled in by the funeral direct	Certification:	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
1-0	क क Medical Certification:	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 21, 2006 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature 33. Date filed (Month, Day, Year) 34. Date filed (Month, Day, Year) 35. Registrar's Signature 36. Registrar's Signature 37. Registrar's Signature 38. Registrar's Signature 39d. Date signed (Month, Day, Year) 39d. Date filed (Month, Day, Year) 39d. Date signed (Month, Day, Year) 39d. Dat

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Frank John Bardecki

	ease Type or Print in aryland / Department o			/giene			
	Certificate o	of Death		Reg. N	· 200	16 283	10
's Name (First, Middle,Last)				2. Date of Death		3. Time of Death	7
NK JOHN BARI	DECKI JR			Month Da August 24, 20	y Year 006	1806 hrs	
Name (if not institution, give street	and number)	4b. City, Town, or L	ocation of Death		4c. County of Deat	h	
Redhill Rd.		Keadysville			Washington	_	
curity Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24Hrs.	8 Date of Birth (M	1	rthplace (State or	
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		Registrar		Cer	tificate d	r Death			R	eg. No.	- 20	116 - 2	831
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ledical Exami		FRANK JOHN	BARDECI	QF. TS					Month August 24	1, 2006	Year	1806	rs
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		5736 Redhill Rd.		,		Keadysv	ille			W	ashingto	n	
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Funeral		o. Social Security Number	U. SEX	r. Age (III yrs, Ia	aacontriday)		Days Hours		C Date of Bil	reian			
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	t	Usual Residence of Decedent											
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daryland 28a-f show 1 at once.	윉	MARYLAND WASH	TINGTON			10f. Zip Co		<u> </u>	1	Oa. Citize	en of What (Country?	
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th the Maryland 23a or 28a-f sho notified at once.		5736 RED HILL					2175					S.A	
h wii	Funeral	11. Marital Status		cedent Ever in U		as Decedent of Yes, specify C)- 1	 Race - A White, et 	merican Indian, c.	Black,
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after	by F	3 Widowed 4 Div	orced If Yes, Give Ye	ar	1	Yes 2 X	No specify	:		S	Specify:	WHITE	
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al Hy	Be C	FRANK JOHN BARDECKI SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St											
2121 ould be fi Mental marked	To B											tate. Zip Code)	
Shou shou and ? 7 is r												21756-00	
MD nd 2 sho alth and m 27 is		DONNA K. BARDE	CKI/SPUU			BOX 5			L L, M Date			y or Town, State	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner muss be notified at once	ı	1 Burial 2 X Cremation	n 3 Removal f		crematory or o		or cerrietery,	'	Date	200. E	Joan - Oil	y or Town, State	
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injin ben Ba		~ 100		ul M. De	ean B	AST FUN	ERAL H					and 217	12
	N //	23a. Part I. Enter the disease, or	complications that	caused the death	. Do not enter	the mode of d	ving, such as o	cardiac or r	espiratory arr	est, shoc	k, or heart	Approxim	nate Interval
Physician /Medical		failure. List only one cause	on each line.										Onset and Death
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	- 1	or condition resulting in death)	Due to (or as	a consequence o	f)·								
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Box e death c the atten	Sici	1 Yes 2 No 9 Un	Lunguage	nant at time of de	eath 5	Other (Specify,				- 1			
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, P.O. Box 6 ires that the death cer signed by the attendi	by	Part II. Other significant condi	·				_	art I.					
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Vit hysic this c	Ö	1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 DOA	Other ₄	Nursing	Home 5	Residen	ce 6 🗸 C	ther: Scene	
n of ling Ph	اۃ!	27. Manner of Death	28a. Date	e of Injury th, Day, Year)	28b. Time o	f Injury 28c	. Injury at Wor	I	8d. Describe	how injur	y occurred		
ondir ath.	١		ding Fnd S		Fnd 5:3	O m 1	Yes 2	, No	unknown				
ision Atternation	<u>8</u>		390 Dia	ce of Injury - At h			_	etc. 2	8f. Location (Street an	d Number o	r Rural Route N	lumber, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri.	ertification:	3 Suicide 6 X Cou	Id not be ermined (Specify		in resi		-	K	eadysvi	State) 5	736 Red	hill Rd.	
Spit:	ပ	4 Homicide	(Opecn)					-					
To the Hos within 24 h To the Fun completely	g	(Check only Certifying P	hysician: To the beaminer: On the basis										
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	ž	29b. Signature and title of certifi	er /	()		29c. L	cense number	r		29d. D	ate signed	(Month, Day, Ye	ar)
		(a Lot	HOR	Van			C.M.E.			Augu	ust 25, 20	006	
										.L			
		30 Name and address of person	who completed car	use of death (Item	23a)								
H		30. Name and address of person Carol Allan, MD As	n who completed car sistant Medica			Street, Ba	Itimore. Mi	D 21201					

State Registrar

AUG 30 2006 32. Redistrar's Sign

State of Maryland / Department of Health and Mental Hygiene Reg. No 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 08 Day 2 2 219 a 0 6 **Physician** 9:03P M MARGARET LOUISE BRINSFIELD /Medical Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner The Pines Genesis HealthCare Easton Talbot 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 M 2 F ILLINOIS Director 213-22-7016 78 Usual Residence of Decedent with the Manyland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County show or other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director EASTON TALBOT or 28e-f Brinsfield, Margaret Louise 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 IISA 610 DUTCHMANS LANE or Itams 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ X o If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: 3
▼ Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene.
7 is markad other than "r Flementary/Secondary (0-12) College (1-4or 5+) DATA ENTRY CLERK **BIO-MEDICAL** 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MILLIE JANE DULANEY CHARLES RUSSELL ADKINS ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health : 8811 BLACK DOG ALLEY, EASTON, MD 21601 KENNETH E. ADKINS/BROTHER A Pages 1 & Jepartment of Hr Important: If ? any injur 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) SPRING HILL CEMETERY 8/28/2006 EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA MERCERON MHOL 200 S. HARRISON ST EASTON, MD 21601 3. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) evebrivesculor accident nears **Physician** /Medical **Examiner** ans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit Due to (or as a consequence of) Box 68760, attending physician Physiclan/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 pronths? 1 ☐ Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably WUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 Yes 25 Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1. Natural Injury 5 Pending death. 1 Yes investigation 2 Accident hours after death unerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8.23.06 30. Name and address of person who completed pause of death (Item 23a) (Type, Print) Michael Crowley 610 Dutchmans Lane Easton, MD21601 31. Date filed (Month, Day, Year) 2006 2. Registrar's Signature State AUG Registrar

Physic		1 - For Amend Item 1 Registra Amend #11 Per IN 1. Decedent's Name (First, Middle, Last) Ralph Andrew	Blake				2. Date of Deat Month 0 8	h Day	^{Үөа} б 6	3. Time of Death 8:35p M	
/Med Exam		4a. Facility Name (If not institution, give st The Pines Genes	reet and number)	nCare	4b. City, Town, East	or Location of Dea	th		y of Death		
Funera Directo		5. Social Security Number 6. Sex 212-16-1122 Usual Residence of Decedent	7. Age (In 86	yrs. last birthday) Yrs.	If Under 1 Yea Months Days			Year) 919		ace (State or Foreign ry) 1and	
e Maryland a-f show	ctor	10a. State 10b. County Maryland Talbot	10c	Easton	ocation				10	od. Inside City Limits	
with tha	Dire	10e. Street and Number			10f. Zip Code	0.1	10	Og. Citizen of	What Count	try?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then *neturel', or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at	by Funeral Director	201 Federal Stre	2. Was Decedent Ever Amed Forces? 1 Yes 2 Who If Yes, Give Year or Dates:	ĺ	Was Decedent of If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)				
within 72 ho ane. Ihen *netur	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	dent's Usual Occi kind of work don DO NOT use retir lity Tec	ed) ed)	orking		of Business/Industry		
d 2 should be filled within 72 hours aft th and Mental Hygene. ?7 is marked other then *neture!; or traumatic event, the Medical Exami	natic event, III	UNK 17. Father's Name (First, Middle, Last) Isaac Blake	:	me (First Middle, A h Gibson ah (Unkno	faiden Suma		Titles				
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permit. Departr Importe eny inje	l)	21. Signature of Funeral Service License	2 X		2. Name and Add Bennie S		eral Home	La	426 Do	ver St 1d.21601	
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cuted id ansit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due Mor as a cor	6.00	generali	ed				years	
sate be executed physician and the burial-transit	Ilcal Exa	resulting in death) Last	Due to (or as a cor						J		
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w requires that the been signed by the should be detache	þ	Part II. Other significant conditions conf	ributing to death but not	t resulting in the u	nderlying cause g	ven in Part I.		acco use cor	ntribute to the	a cause of death?	
Division of Vital Records, after dear dear dear dear dear dearth. To attending Physicien: The law requires the after death. Jinector: Attenthis certificate has been signed in by the funeral director, page 2 should be derification: To Be Completed by							24a. Was ar autops perform 1 Yes 2	/ .	prior to com death?	sy findings available apletion of cause of 2 No	
hysicien nis certifi I director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	2 ☐ ER/Outpatien	it 3 DOA	ther: 4 Nursing I	ath <i>(Check only one</i> Home 5 ☐ Reside		her (Specify,)	
Te Te	atlon:	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	W	uryat ork? □Yes 2□No	28d. Describe ho	w injury occu	rred		
To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	3 Suicide 6 Could not be 4 Homicide determined)	28f. Location (Str City or Town		ber or Rural	Route Number,				
e Hospit 24 hour e Funera Jetely fille	Medical (29a. Certifier Certifying Physic (Check only one)	cian: To the best of my er: On the basis of exar and manner stated.	knowledge, death mination and/or in	occurred at the vestigation, in my	time, date and plac opinion, death occ	e, and due to the ca urred at the time, da	use(s) and m ite and place,	anner as sta , and due to	ated. the cause(s)	
To th within To th comp	Me	29b. Signature and title of certifier 29d. D							d. Date signed (Month, Day, Year)		
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2006 For State Registrar 28313 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** žö 2006 9:08 A M August Helene Margaret Barakauskas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis Sunrise Assisted Living If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 06/13/1931 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 F Connecticut 75 Director 561-98-4421 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 28e-f ehow r than "netural", or iteme 23a or 28e-f ehov the Medical Examiner must be notified at 1 Tyes 2 No Director La Canada Flintridge California Los Angeles 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 91011 238 4732 Palm Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White 1 Yes 2 No Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than College (1-4or 5+) Elementary/Secondary (0-12) Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be fi and Mental F is marked of Helene Margaret McAlenny Paul Vincent Maloney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once. 1173 Claire Road Crownsville Maryland 21032 Edward J. Barakauskas/Son Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State metery 08-25-06 Burlington Connecticut 22. Name and Address of Facility George P. Kalas Funeral Home 08-25-06 4 ☐ Donation 5 ☐ Other (Specify) Center Cemetery 21. Signature of Function 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximale Interval Between Onset and Death Immediate Cause (Final accliac **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical use as the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☑ No Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably (4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificete has birector, page 2 s autopsy performed 2□16 1 ☐ Yes Division of Vital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Tes 2 🗔 No 2 FR/Outpatient 3 DOA neral Director; After this filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 -Natural 5 ☐ Pending 1 ∏ Yes 2 ☐ No death investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely i 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 1000 Registrar's Signature 31. Date filed (Month, Day, Year, State AUG 2 2 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006

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		1	State Registrar		,	Certifica	te of i	Death		Reg	. No.			
to pro-	4 69.		Decedent's Name (First, Middle, Las	1)					1	2. Date of Death Month	Day	Year	3. Time of Death	
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*	/iviedic	115	4a. Facility Name (If not institution, give			4b. City	. Town, o	Location			4c. County of			
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	uneral irector		213-50-5092	7. Age	80 Yr	birthday) Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Month, Day, Y April 03, 19						99. Birthplace (State or Foreign Po26 Waryland		
pur	3	-	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town of	or Location						1	10d. Inside City Limits	
e Maryla	Ba-f sho	Director	Maryland Alle	gany				Midla	nd	10	- Citizen of th	that Cau	1 ☑ Yes 2 □ No	
th with th	23a or 21	ai Dire	10e. Street and Number 14941 Pa	radise Street			ip Code	21542				n of What Country? U.S.A.		
K 1 K 1 J 1 J 2 J 2 J 2 J 2 J 2 J 2 J 2 J 2 J	od other than "natural", or Items 23a or 28a-f show event, the Medical Examinat must be notified at	by Fur	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		13. Was Dec If Yes, sp 1 ☐ Yes	ecify Cuba	lispanic Or an, Mexica Specity	n, Puerto R	ify Yes or No- ican, etc.)		k, White,	can Indian, etc. White	
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aryland should be fil	is marked other than aumatic event, the Ma	To Be	17. Father's Name (First, Middle, Last) Cha	arles Adam Sig						Nadi	dine Wilcox			
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental the Importent: If tem 27 is marked oth any injury or other traumatic event once. To Be (19a. Informant's Name/Relationship (19a James Thomas Be		19b. <i>l</i>					Route Number, , Midland,				
			20a. Method of Disposition 1 ABurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	cemetery,	of Disposition (Name of tery, crematory or other place) Philos Cemetery Date August 26, 2006						Westernport, Maryland			
permit.	Importe sny inju once.		21. Signature of Fundhal Service Licen	Kenzie Fund eet Lonaco	eral Home	P.A.	9							
敏	/sician	Ì	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition		the death. Do not not not not not not not not not no		ode of dyn	ng, such as	s cardiac or	respiratory arre	st.		Approximate Interval Between Onset and Death	
Exa	ledical aminer	iner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b.	a consequence of):								
do/ du, ificate be execut	ysicien and ne burial-trar	icai Examiner	that initiated events resulting in death) Last	c	a consequence of	·):								
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uires that t	signed by	d by Ph	Part II. Other significant conditions of	contributing to death b		the underlying	cause gr	ven in Part	I.				the cause of death?	
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OT VITA Physicien:	is cer direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	ent 2 ER/Out	patient 3	DOA O	her: 4 🗆 N	lursing Hon	ne 5. Reside	nce 6 Oth	er (Spec	ufy)	
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o the	omple	Me	29b. Signature and title of cortifier	/			29c. Licen	se number		29	d. Date signe	d (Month	. Day. Year)	
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	•		30. Name and address of person who	completed cause of c	death (ftem 23a)	Type, Print)	91	7	5/	koy	0-0	Cur	whelan	
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	DI		1. Decedent's Name (First, Middle,	Last)					2. Date of De Month	ath Day	3. Time of Death		
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	or 28g	ie	10e. Street and Number				of. Zip Code			10g. Citizen of V	Vhat Country?		
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Maryland	d be entei ced of	To Be	Truman Wilt					Luvena E					
ar Z			19a. Informant's Name/Relationshi	p (Type, Print)	196	. Mailing Ad	Idress (Street	and Number or Ru			State, Zip Code)		
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altımore,	permit. Pages 1 and Department of Healt Important: If item 27 any injury or other 2 once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Specific Section 2)		20b. Place o cemete				Date 21.20		City or Town, State inger, MD		
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Division of Vital Records,	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by	Drabel	es m	ellitu	4	/		24a. Was	an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?		
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ב כ	ing Pl	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending			Time of Injury N	28c. Injui Wor	ryat rk? Yes 2 ∐ No	28d. Describe	how injury occurr	ed		
1510	Attendi death ctor: A	Certification:	2 Accident investiga 3 Suicide 6 Could no	ot be 28e. Place of Inj	ury - At home, fa			Tes Z INO	28f. Location (Street and Numb	er or Rural Route Number,		
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	To the Hospital or Attenc within 24 hours efter deatl To the Funerel Director: completely filled in by the	Medical (29a. Certifier 1 ☐ Certifying (Check only one)	Physician: To the best kaminer: On the basis of and manner st	f examination an	e, death occu nd/or investig	urred at the ting gation, in my o	me, date end place ppinion, death occur	, and due to the rred at the time,	cause(s) and ma date and place, a	nner as steted. and due to the cause(s)		
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			> 5 Ch	any.	n		D	2563	5	angus	+ 172006		
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1. Decedent's Name (First, Middle, Last) Physician TIES CRADO	
	Date of Death Month Day Year
/Medical THELMA LEE GZADO	August 19 2006 9:25 A M
Examine	n, or Location of Death 4c. County of Death
5 Conict County Number C County T And (In use Institute doubt If Hodge 1 Voc	oma Park Montgomery Park If Under 24 Hrs. 8, Date of Birth 9, Birtholace (State or Foreign
Director 579.90.5723 Security Number 1. Securit	par If Under 24 Hrs. ys Hours Min. Aug. 8, Date of Birth (Month, Day, Year) Aug. 8, 1917 Knoxville, TN
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
out of the state o	1 ☐ Yes 2 ☑ No
Maryland Montgomery Takoma Park 106. Street and Number 106. Street	le 10g. Citizen of What Country?
712 Forston Street 209	12 U.S.A.
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of If Yes, specify Cr	of Hispanic Origin? (Specify Yes or No-
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T. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Lee	Laura Abbot
The discussion of the control of the	eet and Number or Rural Route Number, City or Town, State, Zip Code)
Thaddeus F. Czado/Husband /12 Forston 20a. Method of Disposition (Name of	Street, Takoma Park, Maryland 20912 Date 20c. Location - City or Town, State
20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cametery, crematory or other place) Cate of Heaven C	
20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lio Insee 22b. Place of Disposition (Name of cametery, crematory or other property) 22c. Name and Add HINES-RIN.	Idress of Facility
m ases	WALDI FÜNERAL HOME, INC. Hampshire Ave, Silver Spring, MD 20904
23a. Part1. Enter the asease, or complications that caused the death. Do not enter the mode of descriptions that caused the death. Do not enter the mode of descriptions that caused the death. Do not enter the mode of descriptions that caused the death. Do not enter the mode of descriptions that caused the death. Do not enter the mode of descriptions that caused the death. Do not enter the mode of descriptions that caused the death. Do not enter the mode of descriptions that caused the death. Do not enter the mode of descriptions that caused the death. Do not enter the mode of descriptions that caused the death. Do not enter the mode of descriptions that caused the death. Do not enter the mode of descriptions that caused the death. Do not enter the mode of descriptions that caused the death. Do not enter the mode of descriptions that caused the death. Do not enter the mode of descriptions. ADVANCED DEMENTIA Due to (or as a consequence of): Sequentially list conditions, b.	dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death UNKNOWN
Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
See	
O. of the state of	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 N No 3 Probably 4 Unknown
~ · · · · · · · · · · · · · · · · · · ·	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No
To the second of	26. Place of Death (Check only one)
T Inpatient 2 EH/Outpatient 3 DOA	Other: 4 Nursing Home 5 Aesidence 6 Other (Specify)
25. Was case referred to medical examiner? 1 Yes 2 No	njury at 28d. Describe how injury occurred Work?
To be seen	1 Yes 2 No 28f. Location (Street and Number or Rural Route Number,
27. Manner of Death 1	City or Town, State)
29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in m	e time, date and place, and due to the cause(s) and manner as stated. ny opinion, death occurred at the time, date and place, and due to the cause(s)
L U W	ense number 29d. Date signed (Month, Day, Year)
Carme () ratta m.D.	00034726 AUGUST 21, 2006
Carme () ratta m.D.	

State of Maryland / Department of Health and Mental Hygiene 2006 28317 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** August 18, 2006 Joseph George Caspar 7:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 333 Russell Avenue, #412 Gaithersburg
If Under 1 Year | If Under 24 Hrs. Montgomery 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min **№** M 2□ F Yrs. Director 216-44-9376 95 Washington, Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or itema 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 333 Russell Avenue, #412 20877 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after Heelth and Mental Hygiene. em 27 Is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give altimore. Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: 2 Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Soil Conservation/ Cartographer/Chief of Dept. of Agriculture Reproduction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ida Ruppert George Caspar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Delahay/ Daughter item 27 I 9203 Town Gate Lane, Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H.
Important: If iter
any injury or oth X□ Burial 2 □ Cremation 3 □ Removal from State August 23, * 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2006 Silver Spring, Maryland 22 Name and Address of Facility ins Funeral Home Inc. 21. Signature of Funeral Service Licensee en 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 10 Days a Acute Renal Failure /Medical Due to (or as a consequence of): Examiner b. Nephrosclerosis Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physicien and s the burial-transit The law requires that the death certificate be executed c. H ertension Due to (or as a consequence of) Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Spinal Stenosis, Coronary Artery Disease, Pacemaker, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Chronic Obstructive Pulmonary Disease autopsy performed? 1 Yes 2 🗆 XI o of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ₹ No s after death.

I Director: After this d in by the funeral d 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of To the Hospitel or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical within 2 To the 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number D04115 August 21,2006 W. Killer to 1.6 30. Name and address of person who completed cause of death (Item 23a) (Type. Print)
H. Robert Birschbach, M.D. 201 Russell Avenue, Gaithersburg, MD 20877 H. Robert Birschbach, M.D. 32. Rastrar's Signature 31 Date filed (Month, Day, Year) State Molera AUG 22 2006 Registrar

State of Maryland / Department of Health and Mental Hygienes 28318 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 10:00 P Rosalie S. Callender August 20 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ellicott City Nursing & Rehab Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Months Hours 1 □ M 2 🛣 F 89 Director 152 12 1410 Dec 2, 1916 New Jersev Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r then "naturel", or items 23a or 28a-f show the Medical Examinar must be notified at 1 Tyes 2 No Director MD Ellicott City Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3000 North Ridge Rd 21043 United States death v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 **X**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be f nent of Health and Mental H ant: If Item 27 is marked of Vito Scalera Maria Taccone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul S. Callender/Son 7681 Kindler Rd Laurel, MD 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State = 0 Important: If any injury or once. Crest Lawn Mem. Gard. 8-24-2006 Marriottsville, MD * 4 □ Donation 5 □ Other (Specify) permit. Departn 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 e) 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications the caused the shock, or heart failure. List only one cause on each line. or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner seventially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequen Examiner The law requires that the death certificate be executed and I-trans resulting in death) Last Due to (or as a consequence of): by the attending physician a ached for use as the burial-Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No 24a. Was an autopsy performed? has page this certificate 1 Yes 2 X No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 2 1 ☐ Yes 2 🙀 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) In by 1 4 Homicide 29a. Certifier 🔀 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 eq. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RHunard D0050303 20. Name and address of person who ompleted cause of death (Item 23a) (Type, Print) Rodolfo E. Fernandet 516 N. 516 N. Rolling Rd Ste 205 32. Pogistrar's Signature 31. Date filed (Month, Day, Year) State **AUG 22**

DHMH 17 Rev 1/2001

Registrar

2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2006 1 - For State Registrar 28319 Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death BARBARA CREMINS **Physician** РΜ 17 August 2006 7:15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3253 Chrisland Drive Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Jan. 15, 1 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 K F 555-52-6423 Yrs. 66 Okláhoma 1940 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. Int: if Item 27 ie marked other then "natural; or items 23e or 28s-1 ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23s or 28s-f ehow the Medical Examiner must be notified at 1 TYes 2000 Maryland Anne Arundel Annapolis Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3253 Chrisland Drive 21403 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes ZNNo If Yes, Give Year or Dates: 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 Yes XXNo Specify. Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ben Jones Sybil Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick J. Cremins/husband 3253 Chrisland Drive Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Depertment of Important: if il in only injury or conce. 1 Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cemetery Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 8/22/2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BRAIN TUMOR - NEOPLASIM NOT OMERWISE SPECIFIED Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine or Attending Physicien: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed? Yes 2 1 Yes 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှ 1 ☐ Yes 2 XVo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification; 1) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062349 08-18-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Andrew McGlone 15 2002 MEDICAL PARKWAY SUITE # 670 ANNAPOLIS MD 21401 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 2 1 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 28320 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 13, 2006 5:30 P. Ruth Cadwallader /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 15313 Miner's Avenue S.W. Allegany Frostburg If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Months 1□M 2MF Maryland Director 215-26-6778 78 October 09, 1927 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County if item 27 is marked other than "natural", or items 23s or 28s-1 show or other treumstic event, the Medical Examinar must be notified at 1 Yes 2 No Director Frostburg Maryland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21532 U.S.A. 15313 Miner's Avenue S.W. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other treumatic event, the Medical Examinat once. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Stevenson Lola Rebecca Lashbaugh 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 947 Walnut Grove Road, Baltimore, Maryland, 21221 Sandra Gilpin - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition August 16, I Burial 2 □ Cremation 3 □ Removal from State Laurel Hill Cemetery Moscow Mills, Maryland 2006 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. of Forest Service Licensee 8 East Main Street, Lonaconing, Maryland 21539 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause of aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Dea Immediate Cause (Final disease or condition resulting in death) ancer **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a sonsequence of) Examiner the attending physicien and thed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown been signed by but not resulting in 23e. Did tobacoouse contribute to the cause of death? Part II. Other significant conditions contributing to de ð 1 Pes 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 2 No 1 ☐ Yes filled in by the funeral director, Be 25. Was case referrex 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No 5 esidence 6 □Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural after death. 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide 29a. Certifier ☐ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical

Division of Vital Records, P.O. Box 68760. To the Hospitel or Attending Physicien: 24 hours 8 within 2

> State Registrar

31. Date filed (Month, Day, Year)

e and address of person who completed cause of death

29b. Signature and title of certifier

(Check only one)

96 32. Registrar's Signature

and manner stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registra 006 28321 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 10:45^a M Walter Franklin Davis August 18, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Laurel Regional Hospital Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 27, 1920 86 Feb. Pennsylvania Director 154-14-8886 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 ie marked othar than "natural", or items 23a or 28a-f show other traumatic event, the Mudical Examinar mush be notified at 1 ☐ Yes 2 ☐ No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen ot What Country? ō 20902 USA 2705 Munson Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No It Yes, Give Year or Dates: 0 Specify: White 1 ☐ Yes 2 X No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Susan Irene Hauck Wallace Wilbur Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2705 Munson Street, Silver Spring, MD 20902 Mabel Leiden Davis/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Depertment of H Important: If its eny injury or ot once. 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal trom State August 23, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis of the Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 Klekurd Z 1.60 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** a Respiratory Failure resulting in death) /Medical Due to (or as a consequence ot): Examiner Bilateral Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner History of Supranuclear Palsy attending physicien and for use as the burial-tran Due to (or as a consequence ot): Physician/Medical Congestive Heart Failure IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 XUnknown Completed 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔽 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this tor: After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Momicide within 24 hours a To the Funerel C 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier K' Shah M 118/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 517 7350 Van Dusen Rd # 220 aur 31. Date filed (Month, Day, Year) 32. Restrar's Signature

State Registrar

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

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			State of Maryland / Dep 1 - State Amend #25, perME, g865, 3/17/07 TT Ce	ertificate of Death	Mental Hyg	giene 2006	28322
ı	Physicia	an	Decedent's Name (First, Middle, Last)		2. Date of Dea Month	th Day Year	3. Time of Death
	/Medic		Ruth Deloatch		Aug.	21,2006	4:55 AM
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death	
			Ft. Washington Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Ft. Washingt		Prince Ge	lace (State or Foreign
	Funeral Director		229-30-6546 1 M 2X F 83 Yrs.	Months Days Hours Mir		inia	
			Usual Residence of Decedent		pecti	/1322 VII	11110
	yland		10a. State 10b. County 10c. City, Town or			1	Od. Inside City Limits
	a-f s	cto	Md Prince Georges Ft. Was	hington			1∑Yes 2 No
	or 28	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Coun	try?
	death with the Maryland ms 23a or 28a-f show (must be notified at		8908 Palmer St	20744		U.S.A.	
	er de Itams	Funeral	Armed Forces?	. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - Americ Black, White,	
0000	rs aft	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give 3 ☑ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Bla	ck
ş	within 72 hours after ene. than "natural", or Ita		15. Decedent's Education 16a. Dec	edent's Usual Occupation		16b. Kind of Business/Ind	dustry
	n nin 72	plet	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of wo DO NOT use retired)	orking		
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0	Pages 1 and 2 should be filed within 72 hours after death with the Marylan heat of Health and Mental Hygiens intil fitam 23 a or 28a-f show int: If itam 27 Ia marked other than "natural", or Itams 23a or 28a-f show intil fitam 27 Ia marked other than "natural", or other traumatic event, the Medical Examination into the notified at		1 ⊠Burial 2 □ Cremation 3 □ Removal from State cemetery, cr	ematory or other place)		•	
Бант	mit. Pa partmen cortant: injury ie.			d Mem Park 8-1 22. Name and Address of Facility	24-06	/irginia B	
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×	death certificate be executed e attending physician and nd for use as the burial-transit	ician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	(10)	Continuedia	23d. Date of delive	
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Ž	The ta	ompleted	7/1		autops perfor 1 Yes	med? death?	npletion of cause of
Vital	rician: The lav certificate has rector, page 2	e C	25. Was case referred to medical	26. Place of De	eath (Check only or		
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n or	ding Phys n. After this funeral di		27. Manner of Death 1. → Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)	of 28c. Injury at		ow injury occurred	
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UNISION	fter direct	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (S City or Town	treet and Number or Rura n, State)	l Route Number,
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	To the Hospital or Attanding within 24 hours after death. To the Funaral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) 2 ☐ Medical Examiner: On the bast of my knowledge, de. (Check only one) and manner stated.				
	o the	Me		29c. License number	2	29d. Date signed (Month.	Day, Year)
	Ö 42 ↔		1 200	poo 3706	6	8-21-20	06
(30. Name and address of person who completed cause of death (Item 23a) (Type	e. Print)		-	
1	33		UCHECHI T. OPAIGBEOGU 61886	DKON HILL RD#	701 Oxo	N HILL ME	120745
	Sta		31. Date filed (Month, Day, Year) 32. Refistrar's Signature	29c. License number POO 3706 S. Print) OKON HILL RD#		,	
	Registr	1:10	KUUL Z. A. ZHUD ARREST V				

28323 State of Maryland / Department of Health and Mental Hygiene 106

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			Decedent's Name (First, A	liddle, Las	st)							2. Date of De	ath		v-1.	3. Time	of Death	
	Physici /Medic		Joan E.		Dahli	n						Month August		ay 2006	Year	2:30	a	М
	Examin		4a. Fecility Name (If not insti-	ution, give	street and nur	nber)		4b. Cit	y, Town, o	r Location	of Death			c. County	of Death		-	
			3330 Gleneagles	Driv	e, #1C				Silve	er Spr	ing		į		Mont	gomery		
	Funeral		5. Social Security Number	6. Si		7. Age (In yrs	. last birthday)		er 1 Year	r 24 Hrs.	8. Date of Bi	Birth 9. Birthplace (State or Foreign					ign	
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	or 28	Sire	10e. Street and Number					10f. 2	Zip Code				10g. Citizen of What Country?					
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Baltimore,	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, M												g, MD	209	01	
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Вох	death certificate be executed e attending physicien and ad for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnan	ı	23c. If yes, out	come of pregr		Tectonic	pregnancy	,				23d. Date				
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Division	i or Attend after death Director: /	iffe		uld not be termined	28e. Place	of Injury - At I	nome, farm, sti	reet, facto	ory, office			28f. Location (City or To			r or Aur	al Route Nu	n <i>ber,</i>	
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	_		30. Name and address of per	son who	completed cause	e of death (Ita	m 23a) /Time	Priori						Augu				
(0)	P		Clara Chan, N				a Avenu		‡337 ,	Silv	er S	pring,	MD	20902	2			
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832	Funeral Director		197-44-4232	7. A	ge (In yrs. 53	last birthday Yrs.	Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Bin (Month, Da 12/9/1	952	9. B Pe	irthplace (State or Foreign Country) nnsylvania	í
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B	with the	Director	10e. Street and Number				10f. Zip					10g. Citi	zen of What (Country?	
*		by Funeral	818 Outten Road 11. Marital Status 1 Never Married 2 Married 3 **Midowed 4 Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	? No	.S. 13.				gin? (Spe i, Puerto I	cify Yes or No Rican, etc.)		USA 14. Race - American Indian, Black, White, etc. Specify: white		
ALULIS 21215-0036	be filed within 72 hours after tral Hygiene. Id other than "natural", or ite event, the Madical Exemine	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or		(Give	edent's Usua e kind of wo DO NOT us	rk done d	lurina most	t of workin	of working 16b. Kin			s/Industry	
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Saltimore,	permit. Pages 1 end 2 Department of Health a Important: If Item 27 is any injury or other tre		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	, (Place of Disponentery, creation	ematory or o	ther place		B/22/	/06		cation - City o	r Town, State	
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29€ Vital Records, P.O. Box	or Attending Physicien: The law requires that the death certifications dath. Streetor: After this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ ∀es 2 to No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	al death 3	□Ectopic pr □ Other (sp		. ,			2	23d. Date of d Month	elivery Day Year	
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J. 7	sicien: Th certificate irector, pag	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:		150/0	• • • • • • • • • • • • • • • • • • • •	Othe		377	(Check only	c Philip			-
Division of	nding Phys ath, r: After this e funeral di	ation: To	1 Yes 2 No 27. Manner of Peath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da		28b. Time Injury		28c, Injury Work	4 🗀 Nu	2	ne 5 Residence Residence Residence			ecity)	
Divis	To the Hospital or Attending Ph within 24 hours elter death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, e	njury - At h etc. <i>(Speci</i>	ome, farm, s	treet, factor	y, office		2	28f. Location (: City or Tol			Rural Route Number,	
	ne Hospital n 24 hours ne Funeral I	Medical (29a. Certifier 1 Cartifying Physics (Check only one) 2 Madical Examin	sician: To the besiner: On the basis and manner s	of examina	owledge, dea ation and/or i	th occurred nvestigation	at the tim , in my op	ne, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) date and	and manner and di	as stated. ue to the cause(s)	-
	To the within 2 To the complet	Σ	29b. Signature and trile of condition	/					number	1 1		29d. Dat	e signed (Mo	nth, Day, Year)	
	CUM D		30. Name and address of person who co	empleted cause of	death (Ite	m 23a) (Type	. Print)	licer	ael Fe			8	8/3/	06	
	Dlin		Michael Felder	100	0 6.1	ebroll	51-		SAUS	64	Ms				
	Sta Registi		31. Date filed (Month, Day, Year)	32 Regist	trar's Sign	ature A	DONES!			U					

			1 - For State Registrar	State of M	Maryland / De	epartment Pertificate				ntal Hygi	ene 3. N 2 0 (06	28325
п	Physici	ian	Decedent's Name (First, Middle,	. Last)					2	. Date of Death Month	Day	Year	3. Time of Death
										August	20,2		10:00pM
Andrew O. Erickson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Union Hospital 5. Social Security Number 472_28_6887 10xM 2 F 5. Social Security Number 5. Social Security Number 472_28_6887 10xM 2 F 5. Social Security Number 5. Social Security Number 6. Sex 10xM 2 F 91 Yrs. 10x Indien 1 Year if Under 24 Hrs. 8. Dr. (M. Months) 10x Indien 1 Year if Under 24 Hrs. 8. Dr. (M. Months) 10x Indien 1 Year if Under 24 Hrs. 8. Dr. (M. Months) 10x Indien 1 Year if Under 24 Hrs. 8. Dr. (M. Months) 10x Indien 1 Year if Under 24 Hrs. 8. Dr. (M. Months) 10x Indien 1 Year if Under 24 Hrs. 8. Dr. (M. Months) 10x Indien 1 Year if Under 1 Year if Under 24 Hrs. 8. Dr. (M. Months) 10x Indien 1 Year if Under 24 Hrs. 8. Dr. (M. Months) 10x Indien 1 Year if Under 24 Hrs. 8. Dr. (M. Months) 10x Indien 1 Year if Under 1 Year if Under 24 Hrs. 8. Dr. (M. Months) 10x Indien 1 Year if Under 1 Year if Under 24 Hrs. 8. Dr. (M. Months) 10x Indien 1 Year if Under 1 Year if Under 24 Hrs. 8. Dr. (M. Months) 10x Indien 1 Year if Under 1 Year if Under 24 Hrs. 8. Dr. (M. Months) 10x Indien 1 Year if Under 1 Year if Unde			4c. County										
	F				Age (In vrs. last hirth				24 Hrs. β	. Date of Birth	C	ecil	
ı			472-28-6887			Months			Min.	(Month, Day, 1)	rear) 1,1915	Cour	place (State or Foreign ntry) MN
	and **				10c. City. Town	or Location						1	0d. Inside City Limits
	fsho	ō											1 Yes 2 XNo
	28a	rect			EIRU		Code			100	g. Citizen of V	Vhat Cour	ntry?
	3a ol		65 Willow Ct.			21	921				U.S.A		^
	deat	ner		12. Was Deceder	nt Ever in U.S.	13. Was Decede	ent of His	spanic Orig	gin? (Speci	fy Yes or No-			an Indian,
9	or Its	II.		ed 1X Yes 2]No					can, etc.)		k, White,	
8	ural',	Q D		Year or Dates	5.						Specify	77711	
7	n 72	lete	(Specify only highest		16a. D	ecedent's Usual Give kind of work fe. DO NOT use	l Occupa k done d e retired	ition <i>Juring m</i> ost I	t of working	10	6b. Kind of Bu	isiness/Ind	dustry
212	iene.	mo du		College (1-4c	r5+)						Chrys	s1er	Corp.
þ	Hyg othe		17. Father's Name (First, Middle, L	ast)				18. Mothe	er's Name (/	First, Middle, Ma			
/lar	uld b Menta rrkad	2	Andrew Ericks	son				01:	ina Ko	olfkad			
lan	2 sho and 1 la me		19a. Informant's Name/Relationsh	ip (Type, Print)	19b. N	failing Address	(Street a	nd Numbe	er or Rural F	Route Number, (City or Town,	State, Zip	Code)
	and ealth m 27 har tr			lckson				, E11					
Ö	0 0 = =		1 Surial 2 ☐ Cremation		cemetery,	crematory or oth	her place	1			oc. Location -	•	
Ë	t. Pa rtmen rtant:			**	Elkton					24,	E1ktor	ı, MI)
Ba	permit. Departr Imports any inju		Se Tan			Andre	ew G	. Gee	e Fune	eral Hor	ne		
			23a. Part1. Enter the disease or c shock, or heart failure. List of	complications that caus	ed the death. Do not	259 E	of dying	in St	cardiac or r	Lkton, 1	(D 219	921	Approximate
	Physician	X 19	Immediate Cause (Final	inly one cause on each	line.				1				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or a	as a constituence of)	men	1	cr	est				
	Examiner		Saturatially list conditions	b. GCU	to an	stront	00	tina	1 6	lead	loo.	-02	
13	p ii	Iner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a consequence of)						9		
	ecute and Ftrans	Examiner	that initiated events resulting in death) Last	c. Due to (or o	is a cons fuence of)	24 3	واللا	C.S.	4				
8760,	be executed sician and burial-transit		,	Du to (dr a	is a coris ridence or)	U ala		71-	7	- 10	0-10		
687	ficate by physical streets in the base of	adic		d.	HE TEST	116010	9	CTLO	, May		Por	3772	
Вох	death certificate be executed e attending physician and of for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom							23d. Date	e of delive	rv
	death e atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant	2 ☐ Fetal death at time of death	3 ☐ Ectopic pre- 5 ☐ Other (spe-					Mor	nth	Day Year
P.0	at the de by the stached	hys	9 Unknown	9□ Unknown									
	The law requires that the te has been signed by th rage 2 should be detache	by	Part II. Other significant condition	ns contributing to death	but not resulting in th	e underlying car	use give	n in Part I.		23e. Did toba 1 ☐ Yes	_	ibute to th	ably 42 Unknown
Ö	w requir been si should	etec											
Records,	has by	Completed								24a. Was an autopsy performe	24b. V	Vere autor Fror to cor	osy findings available inpletion of cause of
a		e Co	OF Was ages referred to madical							1 Yes 2		Yes	2[XNo
Vital	sicia cer rect	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: Inpa	tient 2 ER/Outpa	ıtient 3□ DOA	Otho			Check only one)	- C	(01	
of		l⊢.	27. Manner of Death	28a. Date of In	jury 28b. Tim		c. Injury Work			5 Resident			"
ion	Attanding F r death. actor: After by the funera	atlo	1 Natural 5 Pending 2 Accident investiga		<i>Day Year)</i> Inju	ry M		es 2 🗆 N	No				
Division		Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and 28e. Place of I	njury - At home, farm etc. (Specify)	, street, factory,	office		28f	Location (Stre City or Town,	et and Numbe State)	er or Rura	l Route Number,
	spitat or ours afte neral Dira filled in t	Ce											
	ely h	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best xaminer: On the basis and manner:	of examination and/o	eath occurred at r investigation, i	t the time in my opi	e, date and inion, deat	d place, and th occurred	d due to the cau at the time, date	se(s) and ma and place, a	nner as st ind due to	ated. the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier	ſ.	, <u>\</u>	29c.	License	number	, -L ,-	290	. Date signed	(Month, I	Day, Year)
}			10/100	geon Il	77	D	C	Ubl	175	6	8/2	3/2	2006
			30. Name and address of person	no como leted cause of	death (Item 23a) (Ty	pe, Print)		M	1.1	S+ . E	- (1.7		M
5	THIVA		31. Date filed (Month, Pay, Keer)	51550 49	trar's Signature	723	u) 111	CHI	21.6	-IKX	37/	1017
	Sta Registr		31. Date filed (Month, Pay, Xem)	S ZUUB	sever St	grade							

			1- For State Registrar		yland / Dep	artment of I	Health and N	ental Hygid	ene	
	Dhysici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Y	3. Time of Death
			Rose Marie Fignar			,				NA.
	Examir	er				4b. City, Town,	or Location of Death	-		Death
	The Segment of Section (1997) All Missons (Last) Rose Marie Fignar So some Security Number of the Section of Section (1997) All The Section of									
ŀ.			1 D M					(Month, Day, Y		Birthplace (State or Foreign Country)
					, 0	1		July 24	1928	Pennsylvania
	nylan show	_								10d. Inside City Limits
	Ba-fs	cto		ton	Hager	stown				1 ☐ Yes 2X☐ No
	vith th	Dire		Circle		10f. Zip Code	217/2	100		
	sath v	erai	_		-1-11.0	111-5		7 7 7		
	iter de	-une	, , , , , , , , , , , , , , , , , , ,	Armed Forces?	FIN U.S. 13.	If Yes, specify Cub	nispanic Origin? (Sp pan, Mexican, Puerto	ecity Yes or No- Rican, etc.)		
980	urs al	by		f Yes, Give		1 ☐ Yes 2 🛣 No	Specify:		Specify:	white
20	72 ho	ted	15. Decedent's Educatio	on moleted)	16a. Dece	edent's Usual Occu	pation	16	Sb. Kind of Busin	ess/industry
2	ithin	nple			life.			mig		
2	led w tygier her th	S	AT February Manager (Const. Middle 1994)	4		Register				tal
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Ž	hould d Mei mark matic	10		Drint	10h Mail	in a Address (Casse			7 T O.	7.0.11
Baltimore, Maryland 21215-0036	Pages 1 and 2 s nent of Health an nt: If item 27 is i ry or other traui		Jeff J. Fignar (sc 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Remo	on)	13 20b. Place of Disp cemetery, cre	407 Cherr osition (Name of matory or other pla	ry Tree Ci	rcle Hage	erstown c. Location - City	Maryland 21742 or Town, State
alti	rmit. porta porta y inju			7	2	2. Name and Addre	ess of Facility Do	uglas A	Fierv F	uneral Home
<u>m</u>	8 3 E 5 3		Mudors.	Line	1	331 Easte	ern Blvd.	N. Hagers	stown Ma	ryland 21742
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care	ons that caused the	death. Do not en	ter the mode of dyi	ing, such as cardiac	or respiratory arrest	,	Approximate Interval Between
	Physician		disease or condition	Pu	mod Ar	y Pop	MA			Onset and Death
			resulting in death)			1	TCI-S			
L	LAGITITIES	1	Sequentially list conditions, b.			c Cofon	ARY AND	Dry Dist	ASP	
	ed	Jine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):		(1		
	and and	хап	that initiated events c resulting in death) Last	Due to (or as a co	onsequence of):					
8760,	be e sician buris	aiE	M ₁		, , , , , , , , , , , , , , , , , , , ,					
687	ficate physics the	edic	d							
ŏ	n certi	n/M	23h Was decedent programt 230. II			7-			23d. Date of	delivery
m.	death e atte	icia	in the past 12 months?	□Pregnant at tim			у		Month	Day Year
P.0	at the by th tache	hys	9 ☐ Unknown	Unknown						
	es tha		Part II. Other significant conditions contribu			inderlying cause gi	ven in Part I.	23e. Did tobac		
ord	equir sen si ould	ted	Heure AND CHRES	sic te	NM HA	ruce.		1 🗆 Yes	2 □ No 3 □	Probably 4 Unknown
Records,	law ras be	pje	CHRONIC DESTRUCT	TVE Lu	NG ASE	ASE			24b. Wer	autopsy findings available to completion of cause of
		Con	HEPATIC CIPLIE	08(6				performe	d2 deat	h?
/ital	cian: ertific actor,	Be	25. Was case referred to medical				-	(Check only one)		
O	Physical this cal dir		1 185 2 NO	1 L Inpatient		nt 3 DOA	4 Nursing Ho			Specify)
n	Jing After	lon		(Month, Day Ye	ear) 280. Time o			28d. Describe how	injury occurred	
3	death ctor; y the	licat	2 Cuiside 6 Could not be	Re Place of Injury	At home farm et			28f Location /Street	at and Number o	r Dural Bauta Number
Division of	lor A after Direct	ertil	4 Homicide determined	building, etc. (5	Specify)	reet, factory, office				nurai noute Number,
_	spital ours neral filled		29a. Certifier 1 Certifying Physicia	n: To the best of m	v knowledge, deal	h occurred at the ti	me date and place	and due to the caus	se(s) and manne	r as stated
	P S4 h	dic	(Check bill) 2 Medical Examinar:	Un the basis of exa	amination andvor ir	vestigation, in my	opinion, death occurr	ed at the time, date	and place, and	due to the cause(s)
	To th Withir To th comp	Me		_		29c. Licens	se number	29d.	. Date signed (M	onth, Day, Year)
			1 Llan de	Nacs	12.5	D	006428	8 A	La como	22-2006
			30. Name and address of person who comple	ted cause of death	(Item 23a) (Type,	Print)		0.	rous 1 2	-, 000
Í,	H-20		HUDGEN FAR	KAS N	4	MAR	Feed.	VA		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	,				
Ŋ,	Registr	ar	AUG 2 4 2006	Derlen	S. A.	rede				

Consider of Person Justice Marke, Larry Justice				1 - For State Registrar	State of Maryla	and / Depa	artment of H	ealth and Me Death	ntal Hygi	iene 2 0 0 6	28327
46 - Sales Name of the multiplicative part of Casan's 1551 Van Brady Rad Sales Sal		Physici	an	, , , , , , , , , , , , , , , , , , , ,							
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Discretor Comparison Compa		Examir	ner	11511 Van Brady	Road		Upper M	arlboro		Prince Ge	eorges
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23. Part 1 Effer the disease, or complications that caused the death. De not enter the mode of sying, sup as cardiac or respiratory arrest, affocts, or heart failure. List only one cause of each five. Physician // Middlea Examining Securitally is conditions Securitally is conditions Securitally is conditions Securitally is conditions. Securitally in death. Due to (or as a consequence of): Cause of preparation of pregnancy. Securitally in death. Security in death. Securi	121	within 7 iene. then "r	omple		College (1-4or 5+)				-		ıduit
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Physician // Care and Cause (Final care) in the past information cause on each line. Physician // Care and Cause (Final care) in the past information cause of past in the past infor		20240		23a. Part1. Ever the disease, or com	inlications that caused the de						
Due to (or as a consequence of): Sequentially list conditions, if any, liseding to minediate Cause (Disease or Injury that initialized events required or required to the cause of the conditions of the conditio				shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	asla	this c	olon o			Interval Between
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The part of the part is produced by the part is produced by the part of the part of the part is produced by the part of the part is produced by the part of the part is produced by the part of the part of the part is produced by the part of the pa		pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a cons	equence of):					
FFMALE: 23b. Was decedent pregnant in the past 1 horths? 1 leve bird 2 2 leve bird 2 leve bird 2 2	oʻ	e execution and arrial-tran	Exan	that initiated events	Due to (or as a cons	equence of):					
25. Was case referred to medical examiner? Top To		icate be physical s the bu		•	d						
25. Was case referred to medical examiner? Top To	ŏ	h certifi ending use as	ın/Me	23b. Was decedent pregnant			Textonic programmy			23d. Date of deli	very
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25. Was case referred to medical examiner? Top To	Rec	The law ate has i	ompi						autopsy	prior to o	completion of cause of
30. Name and address of person into completed cause of death (Item sea) (Type, Print)	/ita	ertifica octor.	0	25. Was case referred to medical examiner?							Dayahtera
30. Name and address of person into completed cause of death (Item sea) (Type, Print)	€	Physic this o	ဥ		. 1 ☐ Inpatient 2			4 1 Italiang Home			in) Home
30. Name and address of person into completed cause of death (Item sea) (Type, Print)	ou	ding h. h. After funer	tion	Natural 5 Pending) 28b. time of Injury	Work		d. Describe ho	w injury occurred	
30. Name and address of person into completed cause of death (Item sea) (Type, Print)	ivisi	or Atter ter dea liractor n by the	rtifica	3 Suicide 6 Could not b	e 28e. Place of Injury - Al		eet, factory, office	28	f. Location (Str City or Town,	eet and Number or Ru State)	ral Route Number,
30. Name and address of person into completed cause of death (Item sea) (Type, Print)		pitel ours a port a price a pr		29a Certifier 14 Certifying Pt	Iveician: To the best of my k	rowledge deat	Occurred at the tim	e date and place an	d due to the ca	uso(s) and manner as	stated
30. Name and address of person into completed cause of death (Item sea) (Type, Print)		the Hos in 24 ho the Fun ipletely	ledica	(Check only 2 Medical Examone)	niner: On the basis of exam-	ination and/or in	vestigation, in my op	pinion, death occurred	at the time, da	ite and place, and due	to the cause(s)
MB SE D. J. HALDAK MD Climbre, MD		To T To I	Σ	29b. Signature and the or certifier	or lex		29c License	THO X	. 29	od. Pare signed (Mortu	(Pay, Year)
State 31. Date filed (Month, Day, Year) 32. Reg drar's Signature	1	B 1 1		30. Name and address of person who	completed cause of death (II	tem (Type,	Print)	inter	an	1/1	
Registrar AUC 2.4 2006 August D.	4	Sta	ite		32. Regularar's Sig	gnature A	Souls ,	mon',	·		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 0 0 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Aug ation of Death 2006 4:40 P.M. Margaret B. Fatkin /Medical 4b. City, Town, or Location 4c. County of Death 4a Fecility Neme (If not institution, give street and number) Examiner Alleg. Cumberland New Hope II -344 Mt. View Dr. ff Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Funeral Months Days Hours 1 □ M 2 🔀 F Yrs. Director 212-24-0152 1921 MD 1. Usuaf Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental hygiene. Important: if Item 27 is marked other than "naturel," or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County Yes 2□No Director MD Alleq. Westernport 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 213 Miller St 21562 USA by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ▼No Specify Specify: White 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nora Ryan James A. Welsh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 213 Miller St. Westernport, MD 21562 Norleah Fatkin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Scarpelli Crematory 8-21-06 Cumberland, MD 22. Name and Address of Facility 21. Signature of Funeral Service Lip-ne Fredlock Funeral Home Jones St Piedmont, WV 26750 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician FARCTION Immediate Cause (Final disease or condition resulting in death) /Medical Examillier Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be datached for use as the bunal-transit Sequentiafly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yes 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 □Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 • Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 • Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier To the To the To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and aggress of person who completed cause of death (Item 23e) (Type, Print) KHANNA - 625 KENT AU.

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2

2006

32. Registrar's Signature

859 9/7/06 Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 21,22 per hosp. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ERREIRF 05:33 AM 30 2006 /Medical 4c. County of Death 4b. City, Iown, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SHADY GROVE ADVENTIST KOCKVILLE MONTGOMERY ff Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 36 1□M 2ØF Days Hours MARYLAND NONE Director Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or Itams 23a or 28a-f ehor Examiner must be notified at 1 ∰Yes 2 No ERMANTOWN, MONTGOMER by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 334 BIDGE 20874 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1□Yes 2No Baltimore, Maryland 21215-0036 Specify: Specify 3 □ Widowed 4 □ Divorced "naturel" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INFAN Ith and Mental Hygie 27 Is marked other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Peges 1 and 2 should be fit ment of Health and Mental H tant: If Item 27 Is marked ott lury or other traumatic even INKNOWN ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERMANTOWN, MI IVIOTHER cemetery, crematory 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Depertment Important: If eny injury o YCLE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SGAH, 9901 Medical Center Dr., Rockville, MD Dennis Hansen DVR) (per 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Pre Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ter Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown 1 🗌 Yes certificete has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🔽 1 ☐ Yes 2□ No 1 ☐ Yes 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 1 VInpatient ပို 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After this funeral of 28a. Date of fnjury (Month, Day 27. Manner of Death 1 Natural 2 Accident 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending Injury death. 1 Yes 2 No investigation within 24 hours after death To the Funerel Director: completely filled in by the 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated 29b. Signature and title of printifier 29c. License number 29d. Date signed (Month, Day, Year) 70055039 30. Name an address of person who completed cause of death (ftem 23a) (Type, Print) CENTER DRIVE, ROCKVILLE, MARYLAND 20850 MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2006 SEP 0 Registra

State of Maryland / Department of Health and Mental Hygiene

28330 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 0030 **Physician** 8 18 06 Faye A. Glater /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Montgomery 01ney General Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1□ M 2 F Days 108-10-0900 Yrs. May 6, 1917 Albany, NY Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylend nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-1 ahow 10d. Inside City Limits 10a. State 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 ahov any Injury or other traumatic event, the Medical Examinar must be notified at 1X Yes 2 No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, 2921 North Leisure World Blvd. Apt.215 Funeral 20906 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 H No Baltimore, Maryland 21215-0020 Specify. Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Retail Drapery Owner 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle, Last) Rose Paktor Alick Abramson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4400 Hornbeam Drive Rockville, MD 20853 Debra G. Diamond/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 N Burial 2 ☐ Cremation 3 N Removal from State 8-22-06 Schenechady, NY Beth Israel 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction 21. Signature of Funer Service Licensee 1091 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Myocardial Infarction Examiner Due to (or as a consequence of): Examiner Valvular Heart Disease attending physician and I for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? ete has been signed by the a page 2 should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 🗆 Yes 2X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ₺ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? Certification: After t Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident efter death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature, and title of certifier 29c. License number August 18, 2006 B 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter B. Sherer, MD 3921 Ferrara Drive Silver Spring, MD 20906 31. Date filed (Month, Day, Year) egistrar's Signature State AUG Registrar

			1 - For State Registrar	State of Ma		artment of H tificate of L			2006	28331
ī	Physici	an	1. Decedent's Name (First, Middle,	•	GAIT:	משוו			ay Year	3. Time of Death
4	/Medic	al	JOYCE EV	VONNE	GALL	4b. City, Town, or	Location of Dea	August	13,200 tc. County of Dea	
	Examir	er	3200 Spartan			Olne			Montgo	
	Funeral Director		215-58-9084	. Sex 7. Age 1 ☐ M 2 ☐ X F	(In yrs. last birthday) 53 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. Bird	thplace (State or Foreign Suntry) Maryland
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	or 28	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	
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980	urs after de al', or Item Exertiment	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? d 1 □ Yes 2 ☒ N If Yes, Give Year or Dates:	0	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2√2 No	Specify:	to Rican, etc.)	Black, White	e, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23e or 28e-f show minipror other traumatic event, I're Medical Exariginal manual ke indifficat at ance.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 11th	Education grade completed) College (1-4or 5-	(Give	dent's Usual Occupa kind of work done of DO NOT use retired maker	ation during most of wo	nrking 16b.	Kind of Business	
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0 E	nges 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		20b. Place of Dispo	natory`or other plac	θ) 0 /	Date 20c. 23/06 Sa:	Location - City or	
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8760,	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death. To the Funeral Director: After this certificete has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, I any leading I immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	a consequence of):					
.O. Box 6	ne death certific the attending pi thed for use as I	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 12	2 ☐ Fetal déath 3 ☐	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year
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Records,	The law requirelete has been si page 2 should I	Completed						24a. Was an autopsy performed 1 Yes 2 1	prior to death?	utopsy findings available completion of cause of
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Division of Vital	To the Hospitel or Attending Physician: The I within 24 hours effecteath. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ition: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Injur (Month, Day		f 28c. Injur Wor	4 🗆 Nursing	Home 5 Residence 28d. Describe how in		ecify)
Divisi	iel or Atter s efter dea al Director ed in by the	Certification:	3 Suicide 6 Could no 4 Homicide determin		ury - At home, farm, str c. (Specify)	reet, factory, office		28f. Location (Street City or Town, St		ural Route Number,
	To the Hospitel within 24 hours To the Funeral completely filled	edical (29a. Certifier Check only one) Check only	Physician: To the best of xaminer: On the basis of and manner sta	examination and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	e, and due to the cause curred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within To the To the Comple	Me	29b. Signa 4) and title of certifier	/		29c. License	e number	29d.	Date signed (Mon	th, Day, Year)
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			30. Name and address of person w	sherer w	10 39.	21 FP1	rara	Dr U	Theaton	, mp 2099
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State of Maryland / Department of Health and Mental Hygien 0 0 6 28332 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** VIOLET 4:30 A^M W. GDOVIAK 21, August 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner College View Center Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 78 New York Director 112-20-7062 March 26, 1928 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County If item 27 is marked other than "natural", or items 23s or 28s-1 show or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🛛 No Director Maryland Frederick Mount 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5805 Catoctin Vista Drive 21771 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 le marked other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Data Office Assistant State Health Dept. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Andrew Gdoviak Solomon ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5805 Catoctin Vista Dr./ Mount Airy, MD Vera E. Carney / Sister 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If ony injury or Frederick Crematory 08/23/2006 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Lig 1621 Opossumtown Pike/ Frederick, MD 21771 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical Examiner TOKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy to in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? the funeral director Be 26. Place of Death (Check only one) Hospital: Other: ۵ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral I 29a Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 72-2006

DHMH 17 Rev 1/2001

State

Registrar

Hemen

31. Date filed (Month, Day, Year)

Tohnson

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

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State of Maryland / Department of Health and Mental Hygien 2006 28333 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician Albert GANTT, Jr. WJ 24 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 € M 2 □ F 579-09-7249 88 May 17,1918 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits wode Item 27 is marked other than "natural", or Iteme 23s or 28s-f sho other treumatic event, it a Mudical Examinar must be notified at 1 ☐ Yes 2X No Directo Maryland Washington Williamsport 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 16505 Virginia Avenue 21795 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ሺYes. 2 □ No If Yes. Give Year or Dates: 1941–45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: Completed by 3₺ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) maintenance parks permit. Pages 1 end 2 should be file.
Department of Heelth and Mental Hy Importent: If Item 27 is marked otherny injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert Gantt, Sr. Sally Lucretia Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Maenner - daughter 1434 Audubon Road, Hedgesville, W. Va. 25427 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 8/30/06 Grandview Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Johnstown, Pa. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HYPOHIC RESPIRATORY /Medical Due to (or as a consequence of) Examiner PNEUMON: Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit CONGESTIVE HEART Due to (or as a consequence of): of Vital Records, P.O. Box 68760, the attending physician Physician/Medical RENAL PHILURE IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? ğ Month Day 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> CORONARY ARTERY 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? this certificete 1 Yes 2 No or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death | Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 / Inpatient Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending М 1 □ Yes 2 □ No within 24 hours after death To the Funerel Director: A investigation 2 Accident the 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the h 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3H-2+1 DAVID AUTAKO-WIRFOU 251 E. ANTIETOM STREET HAGARITOUN MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 5 2006 Registrar

State of Maryland / Department of Health and Mental Hygiens 28334 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** David Leroy Gentry 8:20 A M August 28, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany 22510 Horserock Road Westernport | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreignorth) | March 15 1953 | West Virginia 7. Age (In yrs. last birthday) 53 Yrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days NOXM 2 F 218-64-8963 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show r then "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at MD. Allegany Westernport 1 Yes 2 100 Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21562 United States 22510 Horserock Road death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Infortant: if item 27 is marked other then "natural", or ite mortant: if item 27 is marked other then "natural", or ite way injury or other traumatic event, the Madical Examina 2018. 1 Yes 25 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16h, Kind of Business/Industry 15 Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Construction Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Leroy Gentry SR. Judith Braithwaite 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeannie Gentry/ wife 22510 Horserock Road, Westernport, Maryland 21562 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 08/31/ 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Westernport, Maryland Philos Cemetery 2006 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Endstag Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a cons auence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine been signed by the attending physicien and should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cete hes page 2 s autopsy perform certificate 1 Yes 2 No After this certifice funeral director, p or Attending Physician: 25. Was case referred to edical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 No 4 ☐ Nursing Home 5 → Tesidence 6 ☐ Other (Specify) Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 Matural 5 ☐ Pending within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Decembring Physician: To the best of my knowledge, death secured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the ! 29b. Signature and title of contifier 28 46U51 30. Name and address of person who pleted cause of death (Item 23a) (Type, Print) 925 Bishop Walsh, Dr., 21502 Dr. Gary Wagoner Cumberland, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2005

			For State Registrar	State of M	farylan	d / Depa <i>Cei</i>	artmen rtificat	t of H e of I	lealth a D <i>eath</i>	ınd M		gien Reg. N		16	28335
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Baltimore,	그 문문을 .		21. Signature of Funeral Service Lice	nsee		2:	2. Name ar	nd Addre	ss of Facility	y HINE	ES RINALI)I FU	NERAL H	IOME.	INC.
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			30. Name and address of person who JASMINE C. GATTI,			n 23a) (Type NSIN AV		02	BETHE	ESDA,	MD 2081	4		/	
			31. Date filed (Month, Day, Year)		strar's Signa										
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State of Maryland / Department of Health and Mental Hygiene 200628336 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Elizabeth 08 Harvey 17 2006 6:49 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Adventist Hospital Takoma Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 反 F 71 Yrs. 577-46-1449 Director DC Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits it if item 27 is marked other than "natural", or items 23s or 28s-1 show of other traumatic event, the Madical Examinar must be routiled at 10a. State 10b. Count 1X Yes 2 □ No Directo Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2219 36th Street SE 20020 USA Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. snt: If Item 27 ie marked other than "natural", or Iteme 23s Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2X No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) US Government Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Andrew Harris Albertha Ferguson Harvey ္ရ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7919 Denwood Avenue; Glen Arden, MD Willie Mae Black / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 08/26/2006 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 3831 Georgia Avenue NW 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 20011 Milliams Washington, DC Latney's Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Erebravasi /Medical Due to (or as a consequence of): Examiner Athrosclerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physicien for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 2 Fetal death 3 Ectopic pregnancy Day Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably Diabe 24b Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a. Was an autopsy performe 1 Yes 2 1 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 2 ER/Outpatient 3 DOA this After the 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No death. М investigation 2 Accident filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after of To the Funeral Direct 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier tmergency 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Takom Pack Washington Adventist ER Humayun 31. Date filed (Month, Day, Year) . Registrar's Signature State 2006 23

Registrar

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r <u></u> ∫	d Men narke	L C	Jcseph Hearin, 19a. Informant's Name/Relationship	Sr.		10h Mailie	a Adden	nn (Stroot :		gare	l Route Numb		lcklan		Codal
Z	permit. Pages 1 and 2 should be Depermient of Health and Menta Important: If item 27 is marked any injury anginer traumatic evance.		Gloria M. Hearin,	•		1	-					-			VA 22150
ē,	Heal Heal Heal		20a. Method of Disposition		20b.	Place of Dispo					ate		Location - Ci		
altimore,	Page nation		1 Burial 2 □ Cremation 3 □ 4 □ Doration 5 □ Other (Speci		State	rkhill			I.	ug 2	3, 200	6 C	Columbi	us,	Georgia
ā	rmit. spertm sporta iy inju		21. Signature of Funeral Service Lio-	nse					ss of Facilit	у Е	verly	Fune	eral Ho	ome	
<u> </u>	90E = 9		Jany M.	Hu	-						Fairf		VA 22	030	
			23a. Part. Enter the disease, or con shock, or heart failure. List only	plications that one cause on	caused the dea each line.	ith. Do not ent	er the m	ode ol dyin	g, such as	cardiac o	r respiratory a	arrest,			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	NTRACER		HEMO	RRHAG	Ε			_			
	Examiner			Due to	(or as a conse	quence of):									
4		her	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conse	qualice of):									
	cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.										_	
, 0	e exe	EX	resulting in death) Last	Due to	(or as a conse	quence of):								T)	
8760,	cate b physic the b	dlcal		_ d											
9 ×	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. Il yes, or	utcome of pregr	nancy							23d. Date of	delive	arv
Вох	death atter	clar	23b. Was decedent pregnant in the past 12 months? 1 \sum Yes 2 \sum No	1 ☐Live 4 ☐ Preg	birth 2 Tet mant at time of	al death 3	Ectopic Other (pregnancy specify)					Month		Day Year
o.	t the c by the	hysi	9 Unknown	9□ Unki	nown										
a, G	es tha igned I	ру Р	Part II. Other significant conditions	contributing to	death bul not re	sulting in the u	nderlying	cause give	en in Part I.						ne cause of death?
ord	w requir been si should						-				1 🗆	Yes	2 A No 3	Prob	ably 4 Unknown
ec	e law I has bu	Completed										psy	pric	or to co	psy findings available mpletion of cause of
<u>a</u>	ician: The certificate ha										1 Yes	ormed? 2 XN		th? Yes	2 No
Division of Vital Records,		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Innationt Of	☐ ER/Outpatier		Othe	oc		(Check only ne 5 ☐ Res		s Dotter	/C 4	
ō	ding Phys I. After this funeral di		27. Manner of Death	28a. Date	of Injury	28b. Time of		28c. Injun Work			28d. Describe				y)
0	tending l	atlo	1X Natural 5 ☐ Pending 2 ☐ Accident investigation	n	nth, Day Year)	Injury	М		k? Yes 2 ☐ I	No					
<u>Xi</u>	l or Attendater deatl Director:	Certification:	3 Suicide 6 Could not t 4 Homicide determined	200. Flac	e of Injury - At I	nome, farm, str	eet, facto	ory, office		2	28f. Location City or To			or Aura	l Route Number,
	oital ours af														
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier 1 X Certifying P (Check only one) 2 Medical Exa	miner: On the	e best of my kn basis of examin nner stated.	iowledge, death ation and/or in	occurre vestigation	od at the time on, in my of	ne, date an pinion, dea	d place, a th occurre	and due to the ed at the time	cause(, date a	s) and mann nd place, and	er as s d due to	tated. o the cause(s)
	omple	Med	29b. Signature and title of certifier	and ma	A A		2	9c. License	e number	1,0-20		29d. D	ate signed (Month,	Day, Year)
)			19/100	1	3	m		01055	104A	(IN)		AL	16,1	8,	2006
	12		30. Name and ordess of person who	ompleted cau			Print)		NA	TION	IAL NAV				
			MICHAEL R. BAYDA		CDR MO				BE	ETHES	DA MD	2088	89-560	0	
	Sta Registi		31. Date liled (Month, Day, Year) ALIG 2 3	2000	agistrar's Sign	B. A	MARKE.	D							

Physician /Medical Examiner

Funeral Director

For State Registrar	(Siret Middle		of Maryla	nd / Dep <i>Ce</i>	artmen rtificate	t of H e of L	ealth a Death	and M	F	Reg. N		06	2833
			UMOON -	frad.					Month _			Year	0
				lor C	4b. City.	Town, or	Location	of Death	00	4			
Howard			/	Cospital)	Cal	. 4						
5. Social Security N 213 18 35	Carpenter Committed Comm			place (State or For									
Usual Residence of 10a. State			10c. C	ity, Town or L	ocation								10d. Inside City Lii
MD	Howa	rd	D	ayton									1 ☐ Yes 2 2
10e. Street and Nur										_			
5090 Gree	enbridg												
		Armed F	orces? 2 ☐ No	_					ecify Yes or No- Rican, etc.)		Bla	ck, White,	etc.
/C			0	16a. Dece	edent's Usua	al Occupa	ation	e of worki		16b.	Kind of B	usiness/in	ndustry
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		_									n Suman	ne)	
				1									o Code)
		gerford/					dge 1						C+-+-
		3 Removal from	n State	cemetery, cre	matory or o	ther place						•	
			Cr										
Stene	- Coll	- W	The same	1 2	4112 C	old C	olum	bia I	Pike El	Lia	ke's ott (Fami City,	MD 2104
shock, or hea Immediate Cause (disease or condition resulting in death)	(Final	_a. Ce	rebrov	asculo					or respiratory ar	rest.			Approximate Interval Between Onset and Death
Sequentially list coif any, leading to incause. Enter Unde Cause (Disease or that initiated events resulting in death) I	injury	c. Hu	y serb; o (or as a conse sertens	on de management de la	n'a								
IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐ No	23c. If yes, o 1 ☐ Live 4 ☐ Pre	utcome of pregr birth 2 Fer gnant at time of	tal death 3									•
Part II. Other signif	icant conditio	ns contributing to	death but not re	sulting in the t	underlying c	ause give	en in Part I						
									autop	sy rmed2		prior to co death?	opsy findings avail ompletion of cause
25. Was case refer examiner?	red to medical	-1					26. Place	e of Death		<i></i>			/
1 ☐ Yes 27X						JA	4 UNI	ursing Ho	me 5 Resid	lence	6 □Oth	er (Speci	fy)
27. Manner of Deat 1 Natural 2 Accident	5 Pending investig	ation (Mo	e of Injury onth, Day Year)		of 2		rat c? Yes 2□		28d. Describe h	iow inj	ury occur	red	
3 Suicide 4 Homicide	6 ☐ Could n determi	ned 280. Plac	ce of Injury - At ding, etc. (Spec		treet, factory	, office			28f. Location (S City or Tow			per or Run	al Route Number,
29a. Certifier (Check only one)	1 Certifying 2 Medical E	g Physician: To the Examiner: On the and ma	ne best of my kr basis of examin nner stated.	nowledge, dea nation and/or i	th occurred nvestigation	at the tim	ne, date ar pinion, dea	nd place, a ath occurr	and due to the o	cause(date a	s) and mand place,	anner as s and due t	stated. to the cause(s)
29b. Signatura and	end E	3 Kotle	MD	- 02-1/7			500			Au	gust	- 21,	Day, Year) 200 4
30. Name and addr	3 CoTVE	who completed ca	5 Ced	on La	n Print)	Col	unk	la	Maryl	and	1 2	1044	1
31. Date filed (Mon	th, Day, Year) AUG 2 2		Pagistrar's Sign	nature	1 10				ı				

State

Registrar

				artment of Health and Mental Hyg ertificate of Death	iene g. No. 2006 28339
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Greer Y. 14011	2. Date of Death Month August	Day Year 1005 Ama
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Funeral		Ellicott City Nursing & Rehab 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Ellicott City If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day,	Howard 9. Birthplace (State or Foreign Country)
	Director		145 32 1432 1□M 2□XF 63 Yrs.	Jan 17	, 1943 New Jersey
	yland now		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits
	e Man	ctor	MD Howard Ellicott	City	1 ☐ Yes 2 ☐ No
	with th	Director	10e. Street and Number		og. Citizen of What Country?
	ns 234	Funeral	3205 Wheaton Way 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or No-	United States 14. Race - American Indian,
9	or Itan		Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 1 No	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:	Black, White, etc.
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural" of Itams 23a or 28a-f show imatic event, the Medical Exerting the notified at	d by	3 ☐ Widowed 4 X Divorced Year or Dates:		Specify: Black
7	in 72 n "nat	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
212	filed withi Hygiene. other than ent, the M	Com	Elementary/Secondary (0-12) College (1-4or 5+) 3 Soc.	ial Worker	State of Maryland
nd	9 - 0 ×	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, M	faiden Sumame)
3	should be tind Mental is markad o	ဥ	Jim Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Maili	Verna Blackwell ing Address (Street and Number or Rural Route Number,	City or Town State Zin Code)
	and 2 s ealth an n 27 is i			Wheaton Way Ellicott City	
altimore,	- I 8 2		20a. Method of Disposition 20b. Place of Disposition cametary, cre	osition (Name of Date 2	20c. Location - City or Town, State
Ĕ	Pages Iment of I tant: If its jury or o				Ellicott City, MD
Ball	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee M01044 2	^{12. Name and Address of Facility} Harry H. Wi 4112 Old Columbia Pike Ell	tzke's Family FH Inc. icott City, MD 21043
П			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	_	Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	or hosis with multion	gan ballue
	Examiner		Due to (or as a consequence or):		
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
	xecute and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):		
8760,	cate be executed oblysician and the burial-transit	dicai E	d		
Ó	ing phi	Medi	IF FEMALE:	· · · · · · · · · · · · · · · · · · ·	
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
o.	that the de led by the a detached t	hysic	1 Yes 2 No 9 Unknown		
s, D	res that igned to be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the conditions		acco use contribute to the cause of death?
ord	w requir been si should I			1 Ye	s 2 No 3 Probably 4 Unknown
Records,	2 8 2	Completed		24a. Was ar autopsy perform	prior to completion of cause of death?
Vital		0	25. Was case referred to medical	1 ☐ Yes 2 26. Place of Death (Check only one	□No 1□Yes 2□No
	d s	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	The state of the s	nce 6 □Other (Specify)
o uc	ding P h. After t funera	ion:	27. Manner of Death Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at 28d. Describe ho Work? M 1 □ Yes 2 □ No	w injury occurred
Division of	or Attanding Physician: after death. Diractor: After this certifici in by the funeral director.	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury, - At home, farm, st	treet, factory, office 28f. Location (Str	reet and Number or Rural Route Number,
2	tal or A s after al Dira ed in by	Certification:	4 ☐ Homicide determined building, etc. (Specify)	City or Town	, State)
	To the Hospital or Attanding Phwithin 24 hours after death. To tha Funeral Diractor: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 2 Medical Exeminer: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and due to the canvestigation, in my opinion, death occurred at the time, da	use(s) and manner as stated. to and place, and due to the cause(s)
	Fo the within 2 To tha complet	Med	29b. Signature and title of certifier	29c. License number 29	d. Date signed (Month, Day, Year)
	02		> sclau	D30641 A	gust 17 2006
13			30. Name and address of person who completed cause of death (Item 23a), Type. Ramed Sapalal 201-105 Back RM	h Neck Road Baltims	V Maylad 2/221
	Sta Registr		31. Date filed (Month, Day, Ylar) AUG 2 2 2006 32. Rustrar's Signature	Gorle	/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 28340 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ROBERTA MACRAE HIGGINBOTTOM AUGUST 6:35PM M 24 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner TALBOT 26200 TUNIS MILLS ROAD EASTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗙 F 87 212-40-9615 Yrs. Director 16, 1918 **NEW YORK** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28a-f show the Modical Examinar must be notified at 1 Yes 2 No Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26200 TUNIS MILLS ROAD 21601 USA r death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 ▼ No Specify þ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Dep-streen of Health and Mental Hygies Importent: If item 27 is marked other th any injury or other traumatic event, Itta once. 12 TEACHER 5+ EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT MACRAE EVA MILNE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARTHUR R. HIGGINBOTTOM/HUSBAND 26200 TUNIS MILLS ROAD, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X remation 3 Removal from State 4 Donation 5 Other (Specify) CHESAPEAKE CREMATION CTR 8/28/2006 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601 MERCEROR JOHN - Z. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cards on each line. Interval Between Opset and Death on each line Immediate Cause (Final disease or condition resulting in death) Syear Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown been signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 12 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes 2 2 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other. 4 Nursing Home 5 XResidence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Director: After the in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physicien:

Baltimore, Maryland 21215-0036

filled in by the f within 24 hours a To the Funeral 6 1 💇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 12

29c. License number

29d. Date signed (Month, Day, Year)

08/25/2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID SMITH M.D., 29466 PINTAIL DRIVE, EASTON, MD 21601

31. Date filed (Month, Day, Year)

32. Registrar's Signature 2

State

Registrar

			For State Registrar	State of Maryland			nt of H te of L		nd Menta	al Hygie _{Reg.}		U 6	28341
			1. Decedent's Name (First, Middle, La	st)						te of Death	Day	Year	3. Time of Death
	Physici /Medio		Virgi	нат.т.					_	rust	L7 20		10.20 M
	Examir		4a. Facility Name (If not institution, give			4b. Cit	y, Town, or	Location of I		usu	4c. County	of Death	10:20 p
1		4.3	7561 East Howa	ard Poad	,	1100	Dur	nio			Anno	7	n d o 1
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. la	ast birthday)		er 1 Year	nie II Under 24 Hours	Hrs. 8. Da	te of Birth onth, Day, Ye	Anne	9. Birthp	ndel lace (State or Foreign itry)
\$10	Director			1 □ X M 2 □ F 71	Yrs.	Month	Days	Hours	Feb		1935		rvland
	ō		219-30-1285 Usual Residence of Decedent										
	how		10a. State 10b. County	10c. City	, Town or Lo	ocation						1	Od. Inside City Limits
	Ma-f-	ţ	Maryland Anne	Arundel Gle	n Bu	rnie							1 X Yes 2 ☐ No
	r 28	ire	10e. Street and Number				ip Code			10g	Citizen of V	What Cour	itry?
	h wit	a D	7561 East Howa	ard Road		2	1060	İ				USA	
	deat deat	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S	5. 13.				n? (Specify Y Puerto Rican,	es or No-		e - Americ	an Indian,
9	after or its	F	1 ☐ Never Married 2 ☐ Married	Armed Forces?					Puerto Hican,	Otc.)		k, White,	
8	ours a	by	3. Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 57–59		1 L Yes	2 ∏ №	Specify:			Specify	" B1	ack
215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f ahow Iteal Evantiner must be notified at	Completed	15. Decedent's E	ducation	16a. Dece	dent's Us	ual Occupa	ation	t working	16	b. Kind of B	usiness/Ind	dustry
21	within 7 ene. than "r	ple	(Specify only highest gri Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	use retired,	tu <i>ring</i> most o)	i working				
21	filed withi Hygiene. other than	ь	12th	0	Mat	teri	al H	andle	r	- Jo	Vesti:	na H	OUSA
	othy oth	Bec	17. Father's Name (First, Middle, Last)	1100	0011	a I		s Name (First				Odbe
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 ahow other traumatic event, it a Medical Examinar must be notified at	To B	Rudo1phu	s Hall				C	amsa	Bur1e	v		
ž	should ind Menior marks	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Addre	ss (Street a		or Rural Rout			State, Zip	Code)
Ž	27 le		Michelle Hall	Davis (Daught	ter)	11	Kent	bury	Ct. (Owina	s, Mi	.11s	Md. 2111
ē,	Health tam 27 tother tr		20a. Method of Disposition	20b. PI	ace of Dispo	osition (N	ame of	1	Date		c. Location -		
<u></u>	Pages nent of I int: If its iry or o		1 Burial 2 □ Cremation 3 □	Juenioval non State M:	metery, crei aryla	natory of nd	Veter	an 8	/25/00	5 C	rowns	vil1	Le, Md.
Baltimore,	글 된 원 공 .		4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Lice		2	2 Name	and Address	s of Facility					
Ba	Department of the post of the		21. Signature of Pulleral Service Lice	A) m	- 2	Wm.	Rees	se_&	Sons l Anna	Mortu	ary,	P.A.	
	40240		Larry D.	7 seese 11004	83	821						214	011
100			23a. Part 1, Enter the disease, or com shock, or heart failure. List only	one cause on each line.	. Do not ent	ter the m	ode or dying	g, such as ca	ardiac or respi	ratory arrest			Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	. luna car	ver	113	etas	tati	C				15 mo
1	/Medical		resulting in death)	Due to (or as a consequ	ence of):	,							
	Examiner		Coquentially list conditions	b									
	7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):								
	outec	Examiner	that initiated events	C									
oʻ	icate be executed physicien and s the burial-transit	EX	resulting in death) Last	Due to (or as a consequ	ence of):								
68760,	sicie sicie pu	edicai		d									
68	ificat g phy as th	edi											
Вох	eath certifi attending I for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar							23d. Da	te of delive	эгу
ä	atte d for	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		JEctopic ∃ Other (pregnancy specify)				Mo	nth	Day Year
o.	that the di ed by the detached	ıysl	9 Unknown	9□ Unknown									
٥	that ed b deta		Part II. Other significant conditions	contributing to death but not resu	Iting in the u	inderlying	cause give	en in Part I.	2:	3e. Did tobac	co use cont	ribute to th	ne cause of death?
Records,	signed b	d by								1X Yes	2 🗆 No	3 Prob	ably 4 Unknown
Ö	w requir been si should	Completed											
ec	elaw hasl	ldu							_ 24	ta. Was an autopsy	246.	Were auto	psy findings available mpletion of cause of
=	The pag	CO							10	performe ∐Yes 2.0		death? I □ Yes	2 🗆 No
Vital	ding Physician: The n. After this certificate hi funeral director, page	Be	25. Was case referred to medical examiner?						f Death (Che	ck only one)			
of \	hysic l dire	10	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 E	R/Outpatier	nt 3 🗆 l	Othe Othe	or: 4 ☐ Nursi	ing Home 5	Residenc	e 6 □Oth	er (Specif	r)
0	nera	:uc	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f	28c. Injury Work	at	28d. D	escribe how	injury occur	red	
.0	ath. or: Al	atle	2 Accident investigation	n		М		Yes 2□No	0				
Division	ar de	iii	3 ☐ Suicide 6 ☐ Could not be determined		me, farm, sti	reet, fact	ory, office		28f. Lo	cation (Streety or Town, S	t and Numb	er or Rura	l Route Number,
Ö	s after	Certification:		Zanomy, Ste. (Opachy					0,	.,			
	hour hour inera y fille		29a. Certifier 1 Certifying Pl	vsician: To the best of my know	vledge, deat	h occurre	d at the tim	e, date and p	place, and du	e to the caus	e(s) and ma	inner as si	ated.
	To the Hospital or Attending Physicien: The law requires that the death certit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be delached for use as	edical	(Check only 2 Medical Examone)	miner. On the basis of examinati and manner stated.	on and/or in	vestigation	on, in my op	oinion, death	occurred at t	ne time, date	and place,	and due to	the cause(s)
	ro th	Me	29b. Signature and Mile of certifier	/ / 1 . 1		2	9c. License	number	0.	29d.	Date signe	d (Month,	Day, Year)
	->-0			1/1/			DO	03869	38		08/	21/2	066
			30. Name and address of person who	completed cause of death (Item Tate Cancer Cen 38 Registrar's Signat	23a) /Tunn	Print)					12	. , .	
	3		Mitch Oh, MD	Le Chiaco C Com	Luay (Type,	205	Hox	121	Dru	0 /4/	enR	ievui	PUD ZIDH
2.0	40.700		31. Date filed (Month, Day, Year)	3# Registrar's Signat	nte	200	100	h. ial	Mari CO	, ,		2-4 hr.	-///
	Sta Registr		ALIC 2 2 20	ing the M	1	00							

		-	For S - State Registrar	tate of Ma	ryland /		irtment of tificate of				giene 0 2 neg	06	28343
	Physicia	an	Decedent's Name (First, Middle, Last) Odessa Jackson			_				2. Date of Dea Month Augus	Day	0 ^v 636	3. Time of Death 6:00A M
	/Medic	al	4a. Facility Name (If not institution, give street	et and number)			4b. City, Town,	or Location			4c. County		0.0011
	V (1)	ngan.	57 Heritage Ct.			friedfacte N	Annap If Under 1 Yea		24 Hrs	9 Date of Bird	Anne		ndel blace (State or Foreign
	Funeral Director		5. Sociaf Security Number 6. Sex 1 ☐ M	2 X∏ F 7. Age	(In yrs. last b	Yrs.	Months Day		Min.	8. Date of Birtl (Month, Day Apr 18	v, Year)	Coui	yland
	70		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation						IOd. Inside City Limits
	Maryla	ō	Maryland Anne Aru	ndel	Anna								1 DvYes 2 □ No
	th the or 28a e notil	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of		ntry?
	ath wi		57 Heritage Ct.	Was Decedent B	Tues in LL C	12.1		401	inin? (Spe	ofy Ves or No	USA 14 Bac		can Indian,
920	72 hours after death with the Maryland natural; or Iteme 23e or 28e-f ehow oteal Exeminan must be notified at	by Funeral	1 M Never Married 2 Married	Was Decedent of Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:			Was Decedent of f Yes, specify Cu 1 ☐ Yes 2XXI			Rican, etc.)		ck, White, y: B1	etc.
Maryland 21215-0036	y within 72 hours after death with the Marylan jiene. r than "natural", or lieme 23a or 28a-1 show the Madical Examinat must be nutified at	Completed		ompleted) College (1-4or 5		(Give	dent's Usual Occ kind of work don DO NOT use reti	e during mos	st of workin	g	16b. Kind of B		dustry
d 21	at,	e Col	11 th 17. Father's Name (First, Middle, Last)	0			None	18. Moth	er's Name	(First, Middle,	None		
/lan	2 should be 1 and Mental I is marked of raumatic eve	To B	Clarence Jackson						у Но				
Aary	2 sho		19a. Informant's Name/Relationship (Type, Mary Robinson (Mo				ng Address (Stre eritaq						
e,	Health Health tem 2		20a. Method of Disposition	oner,			sition (Name of		-	ate	20c. Location		
OE!	Pages nent of ant: If I		1 Burial 2 □ Cremation 3 □ Rem □ Donation 5 □ Other (Specify)	oval from State	Memo	oria	1 Gard	ens	8-21	-06	Davida	sonv	ille, Md.
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta important: If Item 27 is marked eny injury or other traumatic enging.		21. Signature of Funeral Service Licensee	Cero	Ann	apolis	ary, l	P.A. 214	01				
	Physician		23a. Part1. Enter the disease, or complicat shock, or heart faillure. List only one of Immediate Cause (Final disease or condition	ions that caused cause on each lin	the death. D	o not ent	er the mode of d	ying, such as	s cardiac o	r respiratory ar	rest,		Approximate finterval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	ce of):							· ·
Fr.	- # - <u></u>	ler	Sequentially list conditions, if any, reading to immediate	Due to (or as	a ecnesquent	ee of):							
	icate be executed physician and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to les es		ac at):						_	
8760,	be exe		rosoning in douting cast	Due to (or as	a consequent	Ce OI).							
9	tificate ig phys	ledical	d										
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal de	ath 3	□Ectopic pregna □ Other (s <i>pecify)</i>					ate of deliv	rery Day Year
٩	iuires that the signed by the detaction	by	Part II. Dther significant conditions contrib	uger	Syn	ig in the u	nderlying cause	given in Part	l.	23e. Did t	h	tribute to	the cause of death?
Records,	The law requir ste has been s page 2 should	Completed	Chronic	Ane.	mia					24a. Was autor perfo		Were aut prior to co death? 1 \(\text{Yes}	opsy findings available ompletion of cause of
of Vital	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	pital:				Othor		(Check only o	one)		
of	Physic r this c sral dir	- To	1 Yes 21XXXX	1 ☐ Inpatie 28a. Date of Inju	ıry 28	Outpatie	IL SU DOA	njury at Vork?	lursing Hor		dence 6 □Ot how infury occu		ify)
ion	Attending r death. ector: After by the fune	atlo	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y rear)	Injury		Yes 2	□No				
Division	after de Directe	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of fni building, et	ury - At home tc. <i>(Specify)</i>	, farm, st	reet, factory, offi	Ce Ce	1	28f. Location (City or To		ber or Rui	ral Route Number,
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier 1 Certifying Physic (Check only one)		of examination								
	vithin To th	Me	29b. Signature and title of certifier				/	ense number	· /		29d. Date sign	ed (Month	, Day, Year)
			> Drawyll	essis	/mi	2	P	4158	56		8118	106	2
	i		30. Name and address of person who com	. /	death (Item 23		Print) Riva	Rd,	Ann	apo lis	, MO	2/	401
10.00	St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 1 20	32. R	rar's Signature		book			1			

			For State Registrar	State of Man		C860,107 artment of F rtificate of		Mental Hyg	giene 2006	28345
			Decedent's Name (First, Middle, Las	**1		71,110010 01		2. Date of Dea		3. Time of Death
	Physicia	an			Tan			Month	Day Year	
	/Medic		Caleb Redgrav		Jr.				26 2006	
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	1	4c. County of De	ath
			William Hill M			Eastor			Talbo	
	Funeral		5. Social Security Number 6. S	ex 7. Age (/. XDM 2□F	n yrs. last birthday,	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year) 9. B	irthplace (State or Foreign Country)
	Director		- 1 0 0 105	AJM ZUF	95 Yrs.			1-6-19	11Ba	ltimore,Md
	P .		Usual Residence of Decedent		Dc. City, Town or L					10d. Inside City Limits
	hoy	_	10a. State 10b. County		DC. City, Town of L	ocation				Y Yes 2 No
	Pa-f-	cto	Md Talbo	t	Easton					A 163 2 110
	death with the Maryland ms 23a or 28a-1 ehow	Funeral Director	10e. Street and Number			10f. Zip Code		1	log. Citizen of What (Country?
	th wi	aic	501 Dutchmans	Lane		East	on		USA	
	dea ms ms	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H	lispanic Origin? (Span Mexican Puert	pecify Yes or No-	14. Race - An Black, Wh	nerican Indian,
٥	after or its	교	1 Never Married 2 Married	1 Tyes 2 □ No		1 ☐ Yes 2 No	Specify:	, , , , , ,	Specify: W	
2000	d within 72 hours after death with the Marylan jiens, than, "natural; or itams 23a or 28a-1 ehow tre Madical Examiner must be notified at	by	3 Widowed 4 Divorced	Year or Dates:		TEL 163 ZATIO	opecny.		Specify. W	.11 CE
7	72 h	Completed	15. Decedent's Ed (Specify only highest gra	fucation	16a. Dece	edent's Usual Occup e kind of work done	ation	kina	16b. Kind of Busines	s/Industry
-	within 72 ene. than "na	pje	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	9	Self emp	nloved
V	d with	0	12 Years	3 Years	Atto	orney			DOIL CM	J10764
0	othe rent,	Bec	17. Father's Name (First, Middle, Last)			_	18. Mother's Nan	ne (First, Middle,	Maiden Surname)	
land	td be ental ked c	To B	Caleb R. Kelly	y, Sr.			Ethel	Naylor	<u>-</u>	
<u> </u>	shound M mar mat	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street	and Number or Ru	ral Route Number	r, City or Town, State	, Zip Code)
<u> </u>	d 2 in ar		Adine Cockey Ke	- -llv (wife	2325	79 Manle	Hall R	d Clai	iborno N	1d. 21624
a)	1 an Heal Heal em ?		20a. Method of Disposition		20b. Place of Disp	osition (Name of		Date	20c. Location - City of	or Town, State
Ď	Pages nent of int: if it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	-	matory or other place		002006	D	
Saltimor			-				the second second second	802006	Dover, I	De.
žal	permit. Departrimportri		21. Signature of Funeral Service Licer	See // //		2. Name and Addre	•	ov Fund	eral Home	n DC
_	⊈ O 'E € 0		K. Carwoll	Hurry						
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the one cause on each line.	e death. Qo not ef	itell the mode of dyli	ng, such as cardiad	or respiratory arr	PEGCT2, ILC	interval petween
	Physician		Immediate Cause (Final disease or condition	(Land	nerat	un /	neum	one		Onset and Death
	/Medical		resulting in death)	Due to (or as a c	110	0 1		01		
	Examiner			Brac	u Stem	Cerebro	vascula	- Inglan	1	36 hry
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c	onsequence of):		\sim	. /		1)
	nsit	ᄪ	Cause (Disease or injury	Cano	browa	propar	1) cse	i a		Team
	be executed ician and burlal-transit	Examiner	resulting in death) Last	C. Due to (or as a c	onsequence of):					
20	be executed sician and burlal-transit	caiE	l l							
20				0.						
	leath certificat attending phy I for use as the	/Me	IF FEMALE:	23c. If yes, outcome of	pregnancy				33d Date of d	alistont
X Q Q	death o	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death 3	Ectopic pregnanc	У		23d. Date of d Month	Day Year
	the de y the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tirr 9□Unknown	ie or death 5	Other (specify) _				
ī.	res that the de signed by the a i be detached f	Physician/Med		and the single ball along the best of			on in Don't	33e Did to	hanna uea nontributa	to the cause of death?
Ś	The law requires that te has been signed by age 2 should be deta	þ	Part II. Other significant conditions of	ontributing to death but r	not resulting in the	underlying cause giv	en in Part I.			
Kecords	w require been si should b	P	Hyperbensus	~	~ /	10 1		1 🗆 Y	es 2 ☐No 3 ☐ I	Probably 4 □Unknown
ပ္က	aw re s be 2 sh	Completed	Paroxysmul	atrial	1- Un	lotan		24a. Was a	an 24b. Were	autopsy findings available completion of cause of
Ÿ	he ha	E)					autop: perfor	med? death'	?
VITAI	(G LT	Ö	25. Was case referred to medical				26 Place of Dea	th (Check only or		35 21110
5	tending Physician: The law leath. tor: After this certificate has b the funeral director, page 2 s	o B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	ent 3 DOA Ott	-		ence 6 ☐Other (Sp	naifu)
Ö	Phy this ral d	-	27. Manner of Death	28a. Date of Injury	28b. Time				ow injury occurred	ecity)
ב	fter	io	1 ☑Natural 5 ☐ Pending	(Month, Day Y		Wo	rk? Yes 2 □ No		,,	
UIVISION	Attending ir death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be		***		163 2 100	COA Lanation (C	Manaka and Musakas as	Dural Bauta Alumbas
≥	or Al	ŧ	4 Homicide determined	28e. Place of Injury building, etc. (Specify)	treet, factory, office		City or Tow	itreet and Number or i n, State)	nurai nobie Nuribei,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu			1/				<u> </u>		
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Exar	ysician: To the best of r niner: On the basis of ex	amination and/or i	th occurred at the ti nvestigation, in my o	me, date and place ppinion, death occu	, and due to the o rred at the time, o	ause(s) and manner date and place, and di	as stated. ue to the cause(s)
	the I	led	one)	and manner state						
	To To Co⊓	2	29b. Signature and title of certifier	11	100	29c. Licens		_ 2	29d. Date signed (Mo.	nun, Day, rear)
			P Willy	am HW	10d 41	(11)	68715		0/2	100
	10 11		30. Name and address of person who	completed cause of deat	h (Item 23a) Type	, Print)				
_	HV+ C/		William H. Woo	d. Jr. MD	501 Du	tchmans	Land.	Easton.	Md. 216	01
	Sta			006 32. Sistrar's	Signature	R. O.	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

		1	For State Registrar			aryland	Cer	tificat	e of L	Death	2. Date of De		2006	28346
Ph	nysicia	n	Decedent's Name Alma	(First, Middle, Last	-	Lynch					Month	Day		
	Medic xamin		4a. Facility Name (If					4b. City,	Town, or	Location of Death			2006 County of Death	9:44 a M
	Adiriii i				rd Drive,					er Sprir				omery
	neral ector		5. Social Security Nu 577-28-6	500	x 7. Ag □M 2QxF	e (In yrs. lası	00Yrs.	If Under Months	Days	Hours Min.	8. Date of Bir (Month, Da Oct. 14	ay, Year)	905 Mar	hplace (State or Foreign untry) yland
death with the Maryland	ie pe	5		10b. County		10c. City, T								10d. Inside City Limits 1 ☐ Yes 2 No
the M		Director	Maryland 10e. Street and Num	Montgome	ery	Sil	ver S	10f. Zip				10a. Cit	izen of What Co	untry?
3 with	1	2			rd Drive,	#1H		1011 415	209	06			USA	,
DESITIMOTE, METYIERIG ZIZIS-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperminent of Health and Mental Hygiene.	Examiner mu	by Funeral	11. Marital Status 1 ☐ Never Marrie 3 ☑ Widowed 4		12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:					spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White Specify:	
6. 2-0-0 Thin 72 ho	Medical	Completed	(Specif	15. Decedent's Edu fy only highest grad	ucation le completed) College (1-4or:	5+)	16a. Deced (Give life. L	lent's Usu kind of wo DO NOT u	al Occupa rk done d se retired,	ition uring most of work	king	16b. K	ind of Business/	
M bel will you have	3	Cou	12					Hor	nemak	18. Mother's Nam	o (Eint Middle	Maidan		Home
ld be filk		Be	17. Father's Name (F Bernard								a E. Dru		Sumame)	
Marylad 2 should the and Me	raumatic	ျှ	19a. Informant's Nar	me/Relationship (T				-		and Number or Ru th Street	ral Route Numb	er, City o		
Saltimore, no semit. Pages 1 and Department of Health	y or other		20a. Method of Dispo	osition	Removal from State	20b. Plac	e of Disponetery, cren	sition (Name	me of other place	a) Augu	Date st 28,	20c. Lo	ocation - City or	
Dermit. P	eny inju		21. Signatura Fun		_					s of Facilities	Funera	al Ho	ome Inc.	
		T	23a. Part1. Enter th	e disease, or come	lications that cause	d the death.							-	Approximate Interval Between
Physi	ician		Immediate Cause (F	Final	Arterios		ic Ca	rdio	vascu	ılar Dise	ease			Onset and Death 5 Yrs
/Med Exan	dical		resulting in death)		Due to (or as									
LAUII	iiiici	-	Sequentially liet con	iditions,	Hyperten	sive H		Disea	ase					
petr	nsit	Examiner	if any, leading to improve the cause. Enter Under Cause (Disease or in that initiated events	rlying njury	200 (0 (0. 02									
58 / 5U, ifficate be execut	pnysicien and s the burial-transit	I Exa	resulting in death) L	ast	Due to (or as	a consequer	nce of);							
58/50 , ilicate be ex	proysic s the t	edical			d									
BOX to atthe dettif	for use as	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 ☑ 9 □ Unknown	months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	eath 3]Ectopic p] Other (s)					23d. Date of del Month	ivery Day Year
	should be detached	2	Part II. Other signific	_	ontributing to death t	out not resulti	ing in the u	nderlying (ause give	en in Part I.		tobacco		the cause of death?
m 6	N CU	Completed									24a. Was auto perf 1 🗆 Yes	ormed?	prior to death?	utopsy findings available completion of cause of
	certilicete na irector, page 2	BeC	25. Was case referr	ed to medical						26. Place of Dea			, , , , , , , ,	
o È	funeral director, p	္	examiner? 1 Xes 2 1	40	Hospital: 1 Inpati		NOutpatier 8b. Time o		DA Othe 28c. Injury Work	4 Indiang n	lome 5 Res		6 □Other (Speciary occurred	cify)
	tor: Alte	atlor	1 √ Natural 2 Accident	5 Pending investigation		ay Year)	Injury	М		c? Yes 2 □No				
	d in by th	Certification:	3 Suicide 4 Homicide	6 Could not be determined	289. Place of in	jury - At hom tc. (Specify)	e, farm, str	eet, factor	y, office		28f. Location City or To			ural Route Number,
To the Hospital o	s Funere letely fille	Medical C	29a. Certifier (Check only one)		ysician: To the best niner: On the basis and manners	of examination								
To th	comp	Me	29b. Signature and	title of certifier				29	c. License			29d. Da	ate signed (Mont	
10			• (mai	m mo				D24	4543			August	22, 2006
10			30. Name and addre	Rossi,					1d B	lvd., Si	lver Sn	rina	MD 2090)6
	Sta	te	31. Date filed (Mont	h, Day, Year)	32. Regist	rar's Signatur	re .		_	LVU., DI.	rver ph	- 1119	, 110 2000	
R	Registr		А	UG 232	006	u St	1		7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 6 28347 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day **Physician** p Zane Eric Long August 21, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Hospice Casey House
5. Social Security Number 6. Sex 7. / Hours Min. (Month, Day, Year)

Dec. 15, 1962 Washington, DC Montgomery Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 Year Days **Funeral** Months 1 € M 2 □ F Yrs. 43 217-02-4108 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. fnside City Limits 10b. County 10a. State Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🗷 No Director Maryland Montgomery Germantown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13500 Jamison Place 20874 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Pace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No tf Yes, Give Year or Dates: 1 Never Married 2 Married 5 Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 210 MNo Specify: þ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Important: If Item 27 is marked other th
any ijlury pr giber traumetic avant, the
angle. 12 Laborer Government Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Bernard Long Helen Elizabeth Johnson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2122 Arcola Avenue, Silver Spring, MD 20902 Helen J. Long/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition August 24, 1 Surial 2 Cremation 3 Removal from State Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2006 Rockville, Maryland 21. Signature of Funeral Service Licensee 23 Name and Addyss of County ins Funeral Home Inc. Francis University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a Protein-Losing Enteropathy /Medical Due to (or as a consequence of): Examiner Severe Hypoalbuminemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (c) as a consequence of). Examiner and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Recurrent Pleural Effusions resulting in death) Last Due to (or as a consequence of): anding physicien a use as the burial-End-Stage Cardiac Disease Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant etter for L 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Down's Syndrome, Hypothyroidism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2□ No 1 ☐ Yes 2 No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? director Be 26. Pface of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 ROther (SpecifyHospice 1 ☐ Yes 2√XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending investigation after death.

Director: Af
d in by the fur 1 Yes 2 No 2 Accident 6 Could not be 3 🗌 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral C pellij 29a. Certifier 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier august 21, 2006 H0058032 miliam Dilliamo DO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia Williams, M.D. 6001 Muncaster Mill Road, Rockville, MD 20855

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG

Box 68760,

32 Registrar's Signature

2006

23

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ Reg. No. 2006 28348 Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month Dev **Physician** Nancy Dean Lambert Aug 17, 2006 8:00pm /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) Examiner Garrett Oakland Nursing & Rehabilitation Center |
Security Number | 6. Sex | 7. Age (In yrs. last birthday) | Monder | Year Oakland If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 1 □ M 2 🖾 F 5. Social Security Number **Funeral** Months Days Hours Min. 71 Yrs. MD Director June 3, 1935 217 30 1548 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalih and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other treumatic event, the Medical Experiment must be notified at DDES. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 SyYes 2 □ No MD Garrett Be Completed by Funeral Director 0akland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 706 E Alder St 21550 USA 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give ^{XX} Year or Detes: 1 Never Married 2 Married White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Nursing Home Nursing Aid 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Olive Williams Frank Severe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21550 Oakland, MD 117 E Center St. Brenda Severe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State WVU Human Gift Registry 8-18-06 Morgantown, WV 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Burdock-Durst FH 21. Signature of Funeral Service Licenses Oakland, MD undour 21 N. 2nd St. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Luxdiovusculor discose Examiner Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requiras that the death certificate be executed within 24 hours efter death.

To the Funersi Director: After this certificate has been signed by the attending physician and complately filled in by the funeral director, page 2 should be detached for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown pulmonory discase 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Tes 25kNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2 ☐ No 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Accident MD21520 0 Box 247. Naumann MD

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2

2008

32. Registrer's Signature

State of Maryland / Department of Health and Mental Hygiene 2006 28349 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician VIRGINIA** MORTON AUGUST 20 2006 12:06 AM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner COLLEGE VIEW CENTER FREDERICK FREDERICK Birthplace (State or Foreign Country)
 KENTUCKY If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
FEB. 2 1923 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) **Funeral** Days Months Hours 1□ M 27 F Yrs. 406-16-1277 83 Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours aftar death with the Marylan ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23s or 28s-1 show ury or other traumatic event, the Madical Examinat must be nother as 1X Yes 2 No MD FREDERICK FREDERICK Directo 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 700 TOLL HOUSE AVE. USA Funeral 21702 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, be filed within 72 hours aftar de ntal Hygiene. Ind other then "natural", or item Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No Specify: Specify: CAUCASIAN Baltimore, Maryland 21215-0020 2 3 Widowed W Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SHIP YARD WELDER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be PETER MORTON MARY DAVIS 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RICHARD WIMSATT-SON 4100 OLD HWY.13, CUMBERLAND, TN 37050 Pas, spartment or important: If iten, wy injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State NO. VA CREMATORY 8/24/06 ARLINGTON, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility ARLINGTON FUNERAL HOME 21. Signature of Funeral Service Licenses 3901 N, FAIRFAX DR., ARLINGTON, VA 22203 e, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) Weeles /Medical ancer Examiner o (or es e consequence of): Examine attending physician and for use as the bunal-transit Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? certificate has b TO Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) funaral director. 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 X No 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 1 Naturel 5 Pending after daath. 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) à 4 ☐ Homicide 0 To the Hospital within 24 hours a To the Funeral Completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steled.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier edical (Check only 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number D43091 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) House Ave, Frederick Tou Zaidi MO 801 Saced gistrer's Signeture 31. Dete filed (Month, Day, Year) State 2006

Registrar

23

AUG

	Y	:	For State Registrar	State of	f Marylar	nd / Depa <i>Cer</i>	rtme <i>tifica</i>	nt of H	lealth and Death	Men	tal Hygie	ene 2 (006	283	50
	Physici	an	1. Decedent's Name (First, Middle, L Kaye Lorraine Ma	,		-					ate of Death Jonth	Day	Year	3. Time of D	
	/Medic		4a. Facility Name (If not institution, g		nber)		4b. Cit	y, Town, o	Location of Deat		igust :	4c. Coun	006 ty of Death	2:27	<u> </u>
	Funeral		Washington Adven	Sex	pital 7. Age (In yrs.		Tal-	oma er 1 Year Days	Park If Under 24 Hrs Hours Min.	8. D	ate of Birth Month, Day, Y		gomer 9. Birthp	y lace (State or F try)	[∞] oreign
	Director		538-36-8131 Usual Residence of Decedent	1 □ M 2 🗓 F	67	Yrs.		1			7. 2,		Washi		
	yland		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation						1	0d. Inside City	Limits
	Ba-f si	Director		ange		Lag		Nigu	el					1 € Yes 2	□ No
	deeth with the Maryland ms 23a or 28a-f show r must be notified at	Dire	10e. Street and Number 27531 Caesars F	lace			10f. Z	ip Code	92677		100	j. Citizen of	What Coun	try? USA	
20	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "naturel; or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at once.	by Funerai	11. Marital Status 1 Never Married 2 Married	Armed For 1 ☐ Yes If Yes, Giv	∯⊠ No	l!	Yes, sp	edent of Heacify Cuba	ispanic Origin? (S an, Mexican, Puer Specify:	Specify ` rto Ricar	Yes or No- n, etc.)	Bi	ice - Americ ack, White,	etc.	
-003	2 hour	ted b	3 ☐ Widowed 4 € Divorced 15. Decedent's		3165:	16a. Deced	lent's Us	sual Occup	ation		16	6b. Kind of I	Business/Inc	lustry	
2	ithin 73	Completed	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1	-4or 5+)	(Give	kind of v OO NOT	vork done i use retired	during most of wo	orking					
7	iled wi Hygien ther th	Con	17. Father's Name (First, Middle, La	5+		T	eacl	ner	18. Mother's Na	ma (Firs			cary S	chool	
and	id be f ental h ked of ic eve	To Be	Kermit Elsworth						Venice	· .	GIO		ine/		
ary	shou and M s mar	۲	19a. Informant's Name/Relationship			19b. Mailin	g Addre	ss (Street	and Number or Ru				n, State, Zip	Code)	
e, Ma	and 2 lealth m 27 i		Melinda K. Ferr	aro/ Dau	J			_	er Way,						
Saltimore	Pages 1 ment of H ant: If ite uny or ot		20a. Method of Disposition 1√□ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		State	Place of Dispose cemetery, cren Cific Vie	natory or	other plac	Dowl Huge	Date ust 2006	28,		-City or To lel Mar,	wn, State Califor	mia
Dall	Departi Departimbori eny inj		21. Signature of Funeral Service Lic	Ooolo	ey.	50	0 Ur	iver	sity Blv	d, V	V, Silv	er Sp		MD 209	901
	Physician		23a. Part \Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	implications that cally one cause on ea	ach line.				g, such as cardia				FTECT	Approximate Interval Betwee Onset and De	
,	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	,			<u>GT IS</u>	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	uic ()	SPLU		
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec		NE	ARC	770N					DAYS	1
	ecuted and I-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· .	20NA	ey F	1RT	ERY	DISE	745	E			YEAR	S
8/00,	icate be executed physicien and s the burial-transit	dical		d											
	certific nding p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out								23d D	ate of delive	rv	-
5	w requires that the death certif been signed by the ettending should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		irth 2 ∐ Feta ant at time of c		Ectopic Other (pregnancy specify)						Day Yea	аг
Ž.	requires that the	by P	Part II. Other significant conditions				ndertying	cause giv	en in Part I.	:	23e. Did toba	cco use cor	ntribute Io th	e cause of dea	ith?
cords	requir een si hould	sted	STATUS POS	T COP	ONAR	y by	() A	22				2 □ No	3 Prob	ably 4.X∏Uni	known
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<u> </u>	s certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗶 No	Hospital:	npatient 2] ER/Outpatien	1 7 7	Oth	26. Place of Dea er: 4 ☐ Nursing H			6 🗆 O	that (Charle		
	nding Phy th. : After this funeral o	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of (Mont)		28b. Time of Injury		28c. Injur Wor			Describe how			7	
DIVIS	ei or Atter s after dea i Director d in by the	ertification;	3 Suicide 6 Could not determine	be 28e. Place building	of Injury - At h ng, etc. (Speci	nome, farm, stre	eet, facto	ory, office		28f. L	ocation (Stre City or Town,	et and Num State)	ber or Rura	l Route Numbe	r,
	To the Hospitel or Attending Physician: The law within 24 bours after death. To the Funerel Director: Atten this certificate has completely filled in by the funeral director, page 2 or	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the aminer: On the ba and mann	asis of examina	owledge, death ation and/or inv	occurre	d at the tin	ne, date and place pinion, death occu	e, and durred at	ue to the cau the time, date	se(s) and m and place	nanner as st , and due to	ated. the cause(s)	
	within To th	×	29b. Signature and title of certifier				2	9c. Licens				_	ed (Month, I	Day, Year)	
,	10		1 / Wore	She	3	MD		D 3	6207	-	A	4645	T /	8,200	4
	1		30. Name and address of person wh Thomas Charles M	ilitano,	M.D.	7610 C	arro	11 Av	venue, #4		Takom	a Par	k, MD	20912	
	Sta Registr		31. Date filed (Month, Day, Year) ALCG 2 3	2006	egistrar's Sign	de do	arte	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [6 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 2Ó. 2006 10:00 p^M August Sarah L Marcus /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Hebrew Home 8. Date of Birth (Month, Day, Year) Oct. 06, 1910 If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2 1 1 F Texas Oct. 95 Director 459-58-4223 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County in then "naturel", or Items 23e or 28e-f show the Medical Examinations to notified at 1 ☐ Yes 2 X No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20852 United States 6121 Montrose Road nit. Pages 1 and 2 should be filed within 72 hours after death vartment of Health and Mental Hygiene.

Concern: If item 27 is marked other then "naturel", or Items 23storium or other treumatic event. The Medical Examiner rulal injury or other treumatic event. The Medical Examiner rulal exemples. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: If Yes, Give Year or Dates: þ Caucasian 3 XWidowed 4 □ Divorced leted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Compl Flementary/Secondary (0-12) College (1-4or 5+) Accounts Payable Technician 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frieda Weingarten Landesman Wolf 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8221 Lakenheath Way; Potomac, Maryland 20854 Judith C Marcus / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Agudas Achim Cemetery 8/24/2006 | San Antonio, TX ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee any Webert 11800 New Hampshire Ave.; Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OBSTRUCTIVE HRONIC LUNG DISEASE disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Cuarto for as a consequence off Examiner burial-transit signed by the attending physician and d be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I g 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed

Pnysician /Medical Examiner

permit. Page Department of Importent: If

Baltimore, Maryland 21215-0036

1 ☐ Yes 26. lace of Death Check onl one 1 Yes 2 No

25.	. Was case referred to medicate	al
	examiner? 🛶	
	1 ☐ Yes 2 ☐ No	
27	Monn or of Dooth	

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

Other: 4 Jursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

ROSE

28d. Describe how injury occurred

2 Accident investigation 6 Could not be determined 3 🗌 Suicide 4 T Homicide

29b. Signature and title of certifier

5 Pending

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only
one)

1 Natural

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d Date signed (Month, Day, Year) 29c. License number

completed cause of death (Item 23a) (Type, Print) 30. Name and address of p 6121 MI

31. Date filed (Month, Day, Year) State



Registrar

this certificate has I

After

death.

el or Attend s after death

To the Hospitel within 24 hours a To the Funerel I the Hospitel

funeral director,

filled in by

Be

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Division of Vital

			For State Registrar	State of Marylan		artment of H		Mental Hyg	iene 9. N2 0 0 6	28352
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day Year	3. Time of Death
	Physicia /Medic		ELEANOR	FRANCES	Мс	LUCKIE			22, 2006	1:54 P ^M
	Examin	- 4	4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, o	r Location of Deat	h	4c. County of Deal	
1, %		S	Homewood At Crum1		ant histoslavi	Frede		8. Date of Birth	Frederi	.C.K. hplace (State or Foreign
*	Funeral Director		5. Social Security Number 6. Sex 1 C	7. Age (<i>in yrs.</i> i	Yrs.	Months Days	Hours Min.		Year) Co	yland
		-	Usual Residence of Decedent					quite 14,	1717 Hai	y Land
	yland		10a. State 10b. County		, Town or Lo					10d. Inside City Limits
	a-f s	į į	Maryland Frederick	Je	fferso	n				1 Tyes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
	23a		4100 Springview Dr			217			USA	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other treumatic event, the Madical Exam natural treumatic event, the Madical Exam natural treumatic event.	by Funeral	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	'	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2530No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
Ö	tura cal E	ed	15. Decedent's Educ	ation		dent's Usual Occup			16b. Kind of Business	Industry
215	filed within 72 Hygiene. other than *nater, the Mudic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life.	kind of work done DO NOT use retired	during most of wo d)	rking		
212	d with giene pr the	E O	2		Hom	emaker			own hom	<u> </u>
ם	be file tal Hy d oth	Bec	17. Father's Name (First, Middle, Last)					me (First, Middle, M	Maiden Sumame)	
<u>ā</u>	should band marked	2	Harry M. Gross				Mary I			
40	2 shd and is m		19a. Informant's Name/Relationship (Typ		1				City or Town, State,	
ر ا	1 and 2 Health em 27 l		John McLuckie	Son	_	Springvi	Lew Drive		son, Maryla 20c. Location - City or	
20	if of F	1	20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Re		emetery, crei	natory or other plai	etery 8/		Middletown	
Baltimore,	t. Pa rtmen rtant:		4 □ Donation 5 □ Other (Specify) 21. Sign ** re of Funeral Service License			2. Name and Addre				
Ba	permit. Pages 1 and Department of Healt Important: If Item 2' eny injury or other: <u>QDGB</u> .		Sharow Carrie	No Colin	2 1	621 Oposs	sumtown I	ike, Fred	Funeral Hoderick, Ma	cyland 21702
п		/	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the deatl e cause on each line.	n. Do not ent	er the mode of dyir	ng, such as cardia	ic or respiratory arre	est,	Approximate Interval Between Onset and Death
8.0	Physician		Immediate Cause (Final disease or condition	ALZHEIN	ver 's	DEM	ATTINA	-		5 yrs
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):					,
476	*	_	Sequentially list conditions, b.	Due to for as a conseq	namma nille					
	ted nsit	Examiner	ri arry, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (0) 25 2 00.1554	231100 01).					
	al-tra	xar	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	ficate be executed physicien and is the burial-transit	dlcal E								
687	tificate ng phy. as the	edlo								
Вох	eath certifi ettending for use as	Z/M	IF FEMALE: 23b. Was decedent pregnant 23	Bc. If yes, outcome of pregna		75			23d. Date of de	livery
m.	that the death cer ed by the ettendir detached for use	icla	in the past 12 months?	1 Live birth 2 Feta		□Ectopic pregnanc □ Other (specify) _	y 		Month	Day Year
Ö	at the d by the tached	hys	9 ☐ Unknown	9 Unknown				-		
Division of Vital Records, P.O.	The law requires that the death certific ste has been signed by the ettending p page 2 should be detached for use as	Completed by Physician/Me	Part II. Other significant conditions con HYPERTENSION		-	nderlying cause giv			bacco use contribute t es 2 □ No 3 □ P	o the cause of death? robably 4 Onknown
၁၁	aw re as be 2 sho	pie	CRI					24a. Was a autops	n 24b. Were a	utopsy findings available completion of cause of
ř	The page	mo						perform	med? death? 2 No 1 ☐ Yes	
ita	Physician: rthis certifice ral director, p	BeC	25. Was case referred to medical examiner?				26. Place of De	ath (Check only on	ne)	
<u>></u>	hysic his ce i dire	70	1 ☐ Yes 2 ☐ No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA Ot	ner: 4 Nursing	Home 5 ☐ Reside	ence 6 Other (Spe	ocify)
n O	ng P		27. Manner of Death 1 ■ Natural 5 ■ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	rk?	28d. Describe ho	ow injury occurred	
<u>S</u>	Attending in death.	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		4		Yes 2 □ No			
Ξ	or Atl after d Direct	E	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st y)	reet, factory, office		City or Town	treet and Number or R n, State)	urai Houte Number,
	Hospital of hours at Funeral Ditely filled in		29a. Certifier 1 Certifying Phys	icions To the best of multi-	wledge de-	h occurred at the	mo data and all	o and due to the	auco(e) and manner	c etated
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical		ician: To the best of my kno ier: On the basis of examina and manner stated.						
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens			9d. Date signed (Mon	
			1 Druh	nd .		02	1936		8/23/0	6
	4		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type	Print)	- ceasi		6 76012	c 21702
	No. of the		21 Date filed (Month Day Year)	MD 65-C	7 110	mas U.	~~~	de pe	UERIC	102
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 5	32. Registrar's Signal	Jr ,	book				

			For State Registrar	• •		d / Depa		lealth and N	Mental Hyg	giene _{leg. No.} 2006	28353
	Physici		Decedent's Name (First, Middle KATHRYN DER						2. Date of Dea Month		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution REEDERS MEMOR	n, give street and nu			4b. City, Town, o	r Location of Death BOONSB(4c. County of Deat	h
	Funeral Director		5. Social Security Number 216-38-0295	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. Ii 93	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day OCT 5	9. Birti Co 1912 MA	hplace (State or Foreign untry) RYLAND
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County MARYLAND WASH	INGTON	10c. City	, Town or Lo	cation	BORO			10d. Inside City Limits 1X Yes 2 □ No
0	death with the Maryland ma 23a or 28a-f ehow Emust be notified at	Funeral Director	10e. Street and Number 141 south main				10f. Zip Code	21713		10g. Citizen of What Co	
ATHRYN 50036	hours after dea	by Funer	11. Marital Status 1 Never Married 2 Mar 3 XWidowed 4 Divorces	ned 1 ☐ Yes	ve		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ※ No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
CATHR.	if e, INIGITY INIGITY A 1 Z 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Completed I	15. Deceder	nt's Education st grade completed)		16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of world)	king	16b. Kind of Business/	
	died wi	Be	17. Father's Name (First, Middle,			F00l) SERVICE	18. Mother's Nam	,	PUBLIC S(Maiden Sumame)	CHOOL
	Mal ylallo nd 2 should be file lith and Mental Hy 27 is marked oth r treumatic even	To	SAMUEL E. BOWL 19a. Informant's Name/Relations GWENDOLYN M. B	ship (Type, Print)						r, City or Town, State, 2	Tip Code)
VAME:	Dattillore, permit. Pages 1 a Department of Hec Important: if Item eny Injury or othe		20a. Method of Disposition 1 X Burial 2 Cremation 4 Denation 5 Other (5	3 Removal from	State 20b. Pt	ace of Dispo	sition (Name of natory or other place FRAN CEM.	ce)	Date	20c. Location - City or	Town, State
W	permit. Departi Import. eny inj		21. Signature of uneral Service	//cm		Dean I	Name and Addre	SS OF Facility RAL HOME	7606 0 Boonsb	ld National oro, Maryla	Pike and 21713
	Physician /Medical		23a. Part1. Enter the disease of shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a. Ala	each line. Cuelcle	certii		las cardiac	2	A-	Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	b	(or as a consequ						
02260	hat the death certificate be executed that the death certificate be executed ed by the ettending physicien and detached for use as the burial-transit	dical Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):								
93 year O d. obygood Icely to moining	Attending Physician: The law requires that the death certificat cleath. - death. sctor: Atter this certificate has been signed by the ettending phy the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No							ivery Day Year
9	w requires that been signed be should be detailed.	ted by PI	Part II, Other significant conditi	ons contributing to d	leath bul not resu	ilting in the u	nderlying cause giv	en in Part I.		bacco use contribute lo	
200	The law recate has be cate has be								24a. Was a autop perfor 1 Yes	med? prior to death?	topsy findings available completion of cause of 2 No
X	sician: The certificate	o Be	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital	Inpatient 2 🗆 I	EP/Outpotion	nt 3 DOA Oth	26. Place of Dea		ne) ence 6 ⊡Other (Spec	- -
90	To the Hospitel or Attending Physicien: The law within 24 buous elec death. To the Funeral Director: Atten this certificate has completely filled in by the funeral director, page 2	atlon; To	27. Manner of Death 1 Natural 5 ☐ Pendi	28a. Date		28b. Time o Injury	28c. Injur Wor			ow injury occurred	any)
	To the Hospitel or Attending I within 24 hours eiter death. To the Funeral Director: After completely filled in by the tunet	Certification;	3 Suicide 6 Could 4 Homicide deter	nined 286. Place build	ling, etc. (Specify)	eet, factory, office		City or Tow		
	To the Hospitel within 24 hours e To the Funeral I completely filled	Medical	29a. Certifier 1 Certifyi (Check only one) 2 Medical	Examiner: On the b	e best of my knov pasis of examinat nner stated.	wledge, deatl ion and/or in	n occurred at the tir vestigation, in my o	ne, date and place, pinion, death occur	, and due to the c rred at the time, c	cause(s) and manner as date and place, and due	stated. to the cause(s)
•	To the within To the Comp	Ň	29b. Signature and title of certific	My	1		29c. Licens	e number		29d. Date signed (Month	h, Day, Year)
0	DH-16		30. Name and address of person DR ROBERT GUE	DENET, 21	WYAND D	RIVE,	KEEDYSVI	LLE, MARY	LAND 21	756 301-43	2-2222
	Sta Registr DHMH 17 Rev 1/2	ar	31. Date filed (Month, Day, Year AUG 2	5 2006	Registrar's Signat	4. <i>D</i>	ed)				
						ORIGI	NAL				

2006 28354

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

, •		1- For State Control of Department of The Certificate of The Certificate			g. No.	
Physicia	an/	1. Decedent's Name (First, Middle,Last)		Date of Death Month	h	3. Time of Death
al Exami	ner	RYAN KELLY MOORE		August 23,	, 2006	0833 hrs
		,	City, Town, or Location of Death harpsburg)	4c. County of Death Washington	n
F			Under 1 Year If Under 24Hrs	8 Date of Birt		rthplace (State or Foreign
Funeral Director		C14 04 C400 1	Months Days Hours Mir			ountry)
		0 14-24-0483 1 X M 2 F 19 Yrs. Usual Residence of Decedent		T OOL 1	3, 1307	MARYLAND
ans		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
faryland 28a-f show 1 at once.	F	MARYLAND WASHINGTON	SHARPSBURG			1 X Yes 2 No
faryla 28a-f 1 at 91	Director		f. Zip Code	10	g. Citizen of What Cou	ntry?
the 3a or		3129 HARPERS FERRY ROAD	21782		U.S	.A.
th with	Funeral		ecedent of Hispanic Origin? (Sapecify Cuban, Mexican, Puerto		14. Race - Amer White, etc.	ican Indian, Black,
er dea	F	1 Yes 2 X No	s 2 X No specify:		Specify:	WHITE
irs aft tural"	ð.	l or Dates:	Isual Occupation (Give kind of	work done	16b. Kind of Business/	
72 hou	etec		of working life. DO NOT use ret	ired)		
5-0036 led within 77 Hygiene. other than	ompleted	12	FOREMAN			NSTRUCTION
15-003 filed withi I Hygiene. Id other th	ပိ	17. Father's Name (First, Middle, Last)	18.Mother's Name		,	
D 2121 should be fil and Mental F 7 is marked natic event,	O B	JOHN KELLY MOORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ac	dress (Street and Number or	LYNN JU		Zin Code)
J. MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	-		ARPERS FERRY R			/1/8/
		20a. Method of Disposition 20b. Place of Disposition	(Name of cemetery,	Date	20c. Location - City or	
more Pages 1 nent of H ant: If i		1 X Burial 2 Cremation 3 Removal from State crematory or other 4 Donation 5 Other Specify: MOUNTAIN V		28/2006	SHARPSRIIR	G, MARYLAND
Baltimore, permit. Pages 1 at Department of Hee Important: If ite		21. Signatura of Funera Service Licensee 22. Nam	e and Address of Facility		ld Nationa	
w gg ii		Paul M. Dean BAS		Boonsb	oro, Maryl	and 21713
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the n failure. List only one cause on each line.	node of dying, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				Death
		Sequentially list conditions, b				
	ner	if any, leading to immediate Due to (or as a consequence of):				
	Examiner	cuisease or injury mainimated events resulting in death) Last Due to (or as a consequence of):				1
executed an and al - transit		d				
	Medical	UNPENDED AMENDED				
		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal of	Sectoric press	anov	23d. Date of deliver	
ox 68' auth certificate attending for use as	sician/	past 12 months? 4 Pregnant at time of death 5 Other	leath 3Ectopic pregn (Specify)	aricy	Month	Day Year
Box e death c the atten	3	1 Yes 2 No 9 Unknown g Unknown				
P.O.	by P	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.		bacco use contribute to	
S, P.C puires that on signed l				24a. Was a		
ords, aw required as been as b	ompleted			autops perfor	sy prior to	utopsy findings available completion of cause of
tal Rection: The left certificate lector, page	Соп			1 Yes		es 2 No
tal ician: certif	Be (25. Was case referred to medical examiner? Hospital: Inpatient 2 FR/Outnatient 3	26.Place of Death (Check			
of Vital Records, g Physician: The law requir wher this certificate has been s meral director, page 2 should	70	1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 27. Manner of Death 28a. Date of Injury 28b. Time of Injury			Residence 6 Othe	r: Scene
ion of tending Ph. eath. or: After the funeral	ion:	1 Natural 5 Pending Aug 23, 2006 0820 hrs	1 Yes 2 ✔ No		rator of a motorcy	cle
Division tal or Attendir ts after death. al Director: A	ertificati	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, f.	actory, office building, etc.			ural Route Number, City
Divi	erti	4 Homicide determined (Specify) Major Road / Highway		or Town, St Sharpsburg		ille Road, Sharpsb
	sal C	29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred				
To the Hos within 24 h To the Fur completely	ledical	one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.		at the time, date a		
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Mo	
		Mhma Brassell My			/ lugust 24, 2000	,
5H-6		Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD	n Street, Baltimore, MD	21201		
-	ate	31. Date filed (Month, Day Year) 32. Registrar's Signature				
Regis		1110 11 (- '////// Ma	6)			

DHMH 17 Rev 1/2001

ORIGINAL

			For		Marylan						-	ene cegib		0005	_
		•	1 - State Registrar			-	rtificate					, 200	6	2835	5
	Physicia	an	Decedent's Name (First, Middle, Las	t)							Date of Death Month	Day (Year	3. Time of Death	
	/Medic	al	Betty Jane MILEY	-444			45 City To		otion of F	Que	ust.	23 X 4c. County o	506	8:45 P.	М .
	Examin	er	4a. Facility Name (If not institution, give Washington County					own, or Loca ersto		Jeath	9		ningt	on	
	Funeral		5. Social Security Number 6. Sec	эх	7. Age (In yrs.	last birthday)	II Under 1	Year If C	Jnder 24	Hrs. 8.	Date of Birth		9. Birthpla	ace (State or Fore	eign .
	Director		217-32-6314	☐ M 2(3KF	71	Yrs.	Months I	Days Ho	ours !	Min. Ma	Month, Day, rch 18	1935	Mary	yland	
3	, s		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10	d. Inside City Lim	nits
	faho	ō	Maryland Washing	rton		Big Po	0.1							1 ☐ Yes 2 <u>7</u> ☐	
1	128a	Funeral Director	10e. Street and Number	,		D16 10	10f. Zip C	ode			10	g. Citizen of Wi	nat Count	ry?	
1	23a o	alD	11109 Garrison H	Hollow F	Road			217	11			USA			
1	ems des	Iner	11. Marital Status	12. Was Dece Armed For	ces?	.S. 13.	Was Deceder	nt of Hispan y Cuban, M	nic Origin exican, P	? (Specify Puerto Rica	Yes or No- an, etc.)	14. Race Black	- America , White, et		
9	l', or l	by F	1 Never Married 2 Married 3 Widowed 4 XDivorced	1 □ Yes If Yes, Give Year or Da	9		1 ☐ Yes 25	No Sp	ecity:			Specify:	wh:	ite	
3	atura cal E		15. Decedent's Ed	ucation		16a. Dece	dent's Usual (Occupation		, , .	1	5b. Kind ol Bus	iness/Indi	ustry	
7	e. an "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	college (1	-4or 5+)	1	dent's Usual (kind of work DO NOT use	retired)	g most of	r working					
7	ygien herth rt, the		12	0		waı	tress	10	N 1 - 45 - 4 -	N /5	Adiadata Ad	restaur			
	ntai H ed ott	Be	17. Father's Name (First, Middle, Last) George V. William	ns Sr						Carpe		aiden Sumame,	,		
<u> </u>	mark matic	ဥ	19a. Informant's Name/Relationship (1			19b. Mailie	na Address (S					City or Town, S	tate. Zip (Code)	
2 3	is I and 2 should be filed within 72 hours after beauti with the maryland. If Health and Mental Hygiene. Item 27 is marked other than "natural", or liems 23a or 28a-f show other traumatic event, the Medical Examinar must be multiled at		Todd L. Hall - so									Md. 21			
ָב פֿר	of Hero of Hero fitem roths		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Romoval Irom 6	20b. F	Place of Dispo cemetery, crea	sition (Name matory or other	of er place)		Date	2	Oc. Location - C	ity or Tow	n, State	
	reges ment of ant: If it lury or o		4 Donation 5 Other (Specify		Sai	lem Re	formed	Cem.	8	/28/0				Maryland	
	permit. Peges I an Department of Heat Important: If Item 2 any injury or other once.		21. Signature of Euneral Service Licen	1 m			2. Name and					H FUNER			
	101 4 0		23a. Part1. Enter the disease, or comp	plications that ca	aused the deat						<u>_</u>	town, M		Approximate	
	lhysician		shock, or heart failure. List only Immediate Cause (Final	one cause on ea	ach line.	000	1	10	(226	0 0		Interval Between Onset and Death	
	hysician /Medical		disease or condition resulting in death)	a	or as a conseq	uence of):		11(, (WIL		-6	in con y	15.
E	xaminer		Sequentially list conditions	b											
7	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):									
	and al-tran	хап	that initiated events resulting in death) Last	cDue to (or as a conseq	uence ol):									
o,	te be executed ysicien and e burial-transit	calE	(d.											
0	wrequires mai me beam before the executed been signed by the attending physicien and should be detached for use as the buriat-transit														
Š	tendir tendir or use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outo	come of pregnatirth 2 Pete		Ectopic preg	gnancy				23d. Date Mont		y Day Year	
5	the at	yslcl	1 Yes 2 No	4∐Pregna 9∐ Unkno	ant at time of o	leath 5	Other (spec	city)					.,	74y 1041	
	ine law requires mai me beam berrinds ate has been signed by the attending ph page 2 should be detached for use as th	Completed by Physician/Med	Part II. Other significant conditions of	ontributing to de	ath but not res	ulting in the u	nderlying cau	ise given in	Part I.		23e. Did toba	icco use contrib	oute to the	cause of death?	,
cords,	quires n sign uld be	q pe									1 🗆 Yes	2 200 3	3 ☐ Proba	ibly 4 ∐Unkno	wn
2	aw re	plet									24a. Was an autopsy	24b. W	ere autop	sy findings availa	ible
ב ק	ate ha	Com									perform	ed? de	eath?		,
N 1	ector,	Be	25. Was case referred to medical examiner?	Hospital: 📈.				Othor			heck only one				
5	Auending Proystctan: r death. •ctor: After this certifica by the funeral director.	.: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date o		ER/Outpatier 28b. Time o		c. Injury at	Nursi			ce 6 Other			
5	th. :: Afte	atlon	1∠Natural 5 Pending 2 Accident investigation	(Monti	h, Day Year)	Injury	м	Work? 1 ☐ Yes	2 □ No			. ,			
<u> </u>	er dea rector by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place	ol Injury - At h	ome, farm, sti	reet, factory,	office		281.	Location (Stre City or Town,	et and Number State)	r or Rural	Route Number,	
5	ral Di														
	To the footpial or Attending Priystcan: The law within 24 hours after chore. To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2.8	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the niner: On the ba and mann	sis of examina	owledge, deat ution and/or in	h occurred at vestigation, in	the time, dans in my opinion	ate and p	place, and occurred a	due to the cau it the time, dat	ise(s) and man e and place, ar	ner as sta id due to t	ted. the cause(s)	
1	vithin To th	Me	29b. Signature and title of certifier			Carried Control	10 29c. 1	License nur	mber	1	29	d. Date signed	(Month, D	ay, Year)	
			1 tuel	the		_/\		1141	64	13	Ot	124	120	006	
3+	15		30, Name and address of person who	completed cause	e of death (Iter	n 23a) (Type,	Print)	10	1	. Ц	NW a	ito:	10 /	m 217	47)
	Sta	te	31. Date filed (Month, Day, Year)	32. Ry	pistrar's Signa	ature	OFF		1.4	1	440	MIGM	V/) /-	11/2/1	, ,
	Registr		AUG 252	006	Balle so	1. A.	sede				0				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 Amended item#1 & For 4c, MD, TCHD, State of Mar State of Mar 1 - State of Mar No. 108/23/06, sbb 28356 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** MIL 12.40 PM _ Jo Anne T. Miller AUGUST 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Cit If Under 1 Year If Under 24 Hrs. Hospital 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 □ M 2 🔀 F Days Yrs. 226-42-2870 Director WASHINGTON, D.C. 71 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits al Hygiene. I Hygiene de maturell, or Iteme 23a or 28a-f ehow vent, tra Madical Examinar must be notified at TALBOT ST. MICHAELS 1 Yes 2 No MD Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24875 SWAN ROAD 21663 USA filed within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: WHITE þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fit ment of Heelth end Mental H tent; If Item 27 Is marked other. Be FRASIA D. TRICE MILDRED MCKENNEY ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24875 SWAN ROAD, ST. MICHAELS, MD 21663 JAMES R. MILLER, JR./HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or poce. 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR. 8/23/2006 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Joseph 21. 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HODGKINS NON MONTHS LYMPHOMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that in its and one of the content of the conten Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last physicien and Due to (or as a consequence of): Completed by Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐PregnanI at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, PULMONARY CHRONIC OBSTRUCTIVE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No of Vital Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 No this After thi 27. Manner of Death 28a. Dale of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

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completely filled Hospital 29a, Certifier 1 Ccrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10-

31. Date filed (Month, Day, Year) AUG 2 3 2005



MS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

D 0064931

AUGUST 20,

State of Maryland / Department of Health and Mental Hygien 2006 1 - For State Registrar 28357 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 3:50PM M ELEANOR B. MILLER AUGUST 2006 17 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT HOSPICE HOUSE TALBOT **EASTON** If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign 1 M 2 F Months Days Hours MARYLAND Yrs. Director 215-09-2807 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits or Itams 23a or 28a-f show cities must be notified at 1X Yes 2 □ No Director EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 ŏ Specify: Specify: White þ 3X Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETARIAL TECHNICIAN MD STATE HEALTH DEPT. 12 0 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHARLES CARROLL BARRETT EDNA MAUL WERTZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or othar tra CAROL M. LOVELESS/DAUGHTER #79 PARL LANE, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ X remation 3 □ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR. 8/18/2006 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM WUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 JOHN R. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LCAD CHF 20 /Medical Due to (or as a consequence of): Examiner HTN 20 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law raquires that tha death certificate be exacuted COP Due to (or as a consequence of): physician ar Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 De les 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Wasan certificate has 2 1 No 1 Yes Hospital or Attending Physician: Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6\(\bar{\mathbb{X}} \) Other (Specify) \(\bar{\mathbb{HOSPICE}} \) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 TYes 2 No 2 Accident Diractor: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DU40274 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #106 Dn EASTON. 8579 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 2 2006 Registrar

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an	and sm		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailie	ng Address	(Street a	nd Numbe	er or Aura	il Route Numbe	r, City or	Town, State,	Zip Code)	
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7	1		30. Name and address of person wi	no completed cause of	of death (Item	23a) (Type,								1 0	
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State of Maryland / Department of Health and Mental Hygien 2006 28359 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Ruth Lang Nesbitt 11:50 A M August 18 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Calvert Calvert Memorial Hospital Prince Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 13, 1914 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Country) Pennsylvania Hours 1 M 200 177-05-2767 92 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel', or items 23a or 28a-1 show any injury or other traumatic event. The Moutcal Example in unit be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Annapolis Anne Arundel Maryland 1XXX es 2 ☐ No Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21401 U.S.A. 1422 West Street Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify þ If Yes, Give Year or Dates: XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anna Maier Joseph Lang 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 703 Glendon Avenue Annapolis, Maryland 21403 Kathleen Woelfel/friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. 8/22/2006 * 4 ☐ Donation 5 ☐ Other (Specify) Greenwood Cem. Trucksville, PA 21. Signature of Peneral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** typer capacic resp. ratory disease or condition resulting in death) /Medical Du to (or as a consequence of): Examiner Hisiration preumonia Sequentially list conditions, in any, leading to intime diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Examiner The taw requires that the death certificate be executed ongestive hea Due to (or as a consequence of): attending physician a Division of Vital Records, P.O. Box 68760, Physician/Medical rondr IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ stenosis 1 Yes 2 No 3 ☐ Probably 4 ☑ Unknown Completed a ccident vovascular 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Urinar 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Thpatient Other: 1 ☐ Yes 2 ☐ No 2 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / / filled in by the f 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral I 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD 060390 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRINCE FREDERICK JABER 100 HOSP ITAL RO ADEEB Registrar's Signature AUG 2 1 2006 31. Date filed (Month, State Registrar

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	n		1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	th Day Yes	3. Time of Death
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	/Medical		disease or condition resulting in death)	Due to (or as a cons	equence of):					s page
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	D #	ner	Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equienne off):					
	nd trans	Examiner	that initiated events c							
Ŏ,	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or as a cons	equence of):					
8760,	cate b	dicai	d		_				_	
9 X	n certifica Inding pl use as t	Physician/Me	IF FEMALE:	3c. If yes, outcome of preg	100001					
Вох	ath ette for	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o	etaf death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
o	0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	ideam 5	Other (specify)				
ار	₽ 9 9 E	h h	Part If. Other significant conditions con	tributing to death but not r	esulting in the u	nderlying cause give	en in Part Je	23e. Did tob	pacco use contribute	e to the cause of death?
g	uires sign ld be	d by		anema	9 A	eriples	erel	1 □ Ye	s 20 No 3	Probably 4 Unknown
Vital Records,	w require been sig should b	Completed		1	iden	elis i	dised	1 24a. Was a	n 24b Were	autopsy findings available
æ	The lav	mc						autops	y prior ned? death	to completion of cause of
ta		0	25. Was case referred to medical				26 Pface of De	1 ☐ Yes 2 ath Check only on	2.2No 1 □ Y	'es 2 € No
	Physician: rthis certific ral director,	To B	examiner?	ospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Othe	06	- 22	ence 6 Other (S	'necify)
Division of	ding Ph		27. Manner of Death	28a. Date of fnjury (Month, Day Year)					w injury occurred	pos.,y/
<u>ō</u>	Attending r death. ector: After by the funer	atic	1-☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(, 22)	,ury		Yes 2 □No			
Š	_ 0 -	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, sti	reet, factory, office		28f. Location (St. City or Town	reet and Number or n, State)	Rural Route Number,
	ital ol irs aft rel DI									
	e Hospital 24 hours a e Funerel D letely filled i	edicai	(Check only 2 Medical Examin	ician: To the best of my k	nowledge, deat nation and/or in	h occurred at the tim vestigation, in my or	ne, date and place pinion, death occi	e, and due to the caurred at the time, da	ause(s) and manner ate and place, and o	as stated. tue to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.	1 . 14					
•	5.3 £ 8	- Control	and the or partition	- June	a reg	Po	0200	940	Julio Signific [Wi	23/06
	ar l		30. Name and address of nevers who are	maleted cause of death (to	em 23a) /Tue-	Print) 4	-	01	-	
)0			30. Name and address of person who co	- M	7//	14 Du	len i	More	9d. Date signed (Me	conounce
	Sta	te	31. Date filed (Month, Day, Year)	32. Resistrar's Sig	nature					71356
	Registr		AUG 2 4 20	306 Mene	K. A	back				1 200

State of Maryland / Department of Health and Mental Hygieney

28361 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death Month **Physician** NAIR Norma Jean August 17, 2006 7:45 AM /Medical 4b. City, Town, or Location of Daath 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Garrett Oakland Nursing and Rehab Center Oakland If Under 1 Year | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗓 F Yrs Director 214-36-6787 69 2/6/1937 Maryland Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No Director Mountain Lake Park MD Garrett 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 110 A St., #109 21550 Funeral 13. Was Decedent of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 ☐ Yes 2 X No If Yes, Giva Yaar or Dates: 1 ☐ Naver Merried 2 X Married 1 ☐ Yes 2 X No Specify: 2 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 12 Housewife Home 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be C. Teets Emmaline С. Savage ၉ Orval 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl W. Nair/ Husband 110 A.St., #109, Mountain Lake Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Date 1 Burial 2 □ Cremation 3 □ Removal from State Pleasant Valley Cemetery 8/20/06 Oakland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility 21. Signature of Funer 32 S. Second St. Stewart Funeral Home Oakland, MD 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** Mellitus Tope II Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner nding physician end use as tha bunal-trensit or Attending Physician: The law requires that the deeth certificeta be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Ceusa (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Due to (or as a consequence of): use as t 23b. Did tobacco usa contributa to tha causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ģ Completed 24b. Were autopsy findings 24a. Was an autopsy performed? available prior to completion of cause of death? pege 2 has t Vas 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Wind Nursing Home 5 Residence 6 Othar (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Tima of 28d. Describe how injury occurred 1 X Natural 5 Pending s efter death. I Director: Af 1 Yes 2 No investigation 2 Accidant 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) á 4 Homicide filled within 24 hours e To the Funeral C Hospital Medical 29a. Certifier 1[X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H26154 8/18/06 of death (Item 23a) (Type, Print) Thorn berry Ral Oakland MD 2156 Do 186 Daniel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 21 2006 Registrar

	er .	For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryland	d / Depa <i>Cer</i>	rtment of He tificate of D	ealth and Meath	Mental Hyg R 2. Date of Deal	og. 110.	06 28362
Physicia /Medic Examin	al	J. Richard 4a. Facility Name (If not institution, give st 6166 Telegraph Roa	eet and number)		4b. City, Town, or L Elkton	ocation of Death	fugast	_	96 09; 20A) Death
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. Iz	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) April 2	Year) 2,1958	9. Birthplace (State or Foreign Country) Wilmington,
the Maryland 28a-f show	Director	10a. State 10b. County MD Cecil 10e. Street and Number	,	, Town or Lo	cation		1	0g. Citizen of Wh.	10d. Inside City Limits 1 ☐ Yes 2 ☑ No at Country?
within 72 hours after death with the Maryland ene. than "naturel", or items 23a or 28a-f show fre Moulcal Examinant be notified at	by Funeral	6166 Telegraph Roa 11. Marital Status 1 Never Married 3 Widowed 4 Divorced	td. 2. Was Decedent Ever in U.S Armed Forces? 1 _Yes _2 No If Yes, Give Year or Dates:	-	21921 Vas Decedent of His i Yes, specify Cuban	panic Origin? (Sr , Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		American Indian, White, etc. white
ed within 72 ho ygjene. her than "natur it, Ire Mudical	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		(Give life. L	lent's Usual Occupat kind of work done du DO NOT use retired) hanic	ring most of wor	king		y School Dist
d 2 should be filed to an and Mental Hygist Is marked other traumatic event, It	To Be	17. Father's Name (First, Middle, Last) Richard M. Orr 19a. Informant's Name/Relationship (Typ)	- Ocint)	10h Mailig	g Address (Street ar	Marg	aret Kel		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examination to infilted at one.		Malynda Alberti On 20a. Method of Disposition 1 Xeurial 2 Cramation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Fune al & Prior Tice Alexandre	meval from State 20b. Pl	ace of Dispo emetery, cren L Sain	6 Telegram sition (Name of natory or other place ts Cemeter . Name and Address	ry Aug.	24,2006	20c. Location - Ci Wilmin 'uneral H	lomes, Inc.
Physician and physician and physician and physician and physician and the purish-transit	Ilcal Examiner	23a. Part1. Enter the disease, or complice shock, or heart failure. Eist only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last d. d.	Due to (or as a consequence to (or as a consequence)	Lence of):	924 Concorrection mode of dying	such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3[Ectopic pregnancy Other (specify)			23d. Date Month	,
requires been sign should be	Completed by Pl	Part II. Dther significant conditions cont	nbuting to death but not resu	ilting in the u	nderlying cause give	n in Part I.	1 □ Y 24a. Wasa	es 2 X No 3	ute to the cause of death? Probably 4 Unknown ere autopsy findings available
Physician: The law this certificate has ral director, page 2 !	Be	25. Was case referred to medical examiner? 1 ★ Yes 2 □ No	spital: 1 Inpatient 2 i	ER/Outpatien	t 30 DOA Other	-	ath (Check only or	med? dea 202 No 1 D	or to completion of cause of ath? Yes 2 No
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	al Certification: To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Physi	28a. Date of Injury (Month, Day Year) Angles W 2016 28e. Place of Injury - At ho building, etc. (Specify A D M Cian: To the best of my know	28b. Time of Injury 09' 24 me, farm, str) wledge, death	28c. Injury Work 1 Y eet, factory, office	at ? es 2 A No e, date and place	28d. Describe h 28f. Location (S City or Tow 61667	treet and Numbern, State)	gun shot Loum of Aural Route Number, LE/kTong.
To the Ho within 24 f To the Ful completely	Medical	29b. Signature/and title of certifier What Jacks,	pr: On the basis of examinat and manner stated. The properties of death (Item 32. Registrar's Signat 106)	ion and/or in	29c. License	number	arred at the time, o	date and place, and 29d. Date signed ((Month, Dey, Year)
Sta Registi		H Farkes,	1P Unite 32. Registrar's Signal	on Ho	spital,	2//20	n, 10		

			Trogramma - / /	artment of Health and Martificate of Death	Reg	ene . No 2005	
**************************************	Physicia	an	1. Decedent's Name (First, Middle, Last) Sadie Owens		2. Date of Death Month August	Day 2006	3. Time of Death 10:05P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Future Care	4b. City, Town, or Location of Death Arnold		4c. County of Dea	
. € •£**	Funeral Director		5. Social Security Number 6. Sex 1 M 2 K 79 Yrs. 1 Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y Feb 12	9. Bir 1927 Mai	thplace (State or Foreign ountry) Cyland
	Maryland -f show	ğÌ	10a. State 10b. County 10c. City, Town or L Iaryland Anne Arundel Glen B	_			10d. Inside City Limits
	or 28a	Funeral Direc	10e. Street and Number Furnace	10f. Zip Code		J. Citizen of What Co	ountry?
	na 23a	eral	6415 Cedar Furance Circle 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21061 Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto		USA 14. Race - Amo	
036	72 hours after death with the Maryland natural', or itema 23a or 28a-f show Jisal Examilian mat be maiffed at	þ	Amed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 Ano Specify:	Rican, etc.)	Black, Whi	te, etc. Black
Maryland 21215-0036	within ene. then	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation a kind of work done during most of work DO NOT use retired) tary Tech	A	sb.Kind of Business nne Arur edical (nde1
nd	d be filed ntal Hygi ed other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Ma		
ryla	should be nd Mental marked	ပ္	Charles Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	Maggie ing Address (Street and Number or Ru		City or Town, State,	Zip Code) 21061
Ma,	and 2 selth and 2 s 27 la			Lamplighter Ri			
Baltimore,	. Pages 1 and 2 should be iment of Health and Menta tant: If itam 27 ta marked fury or other traumatic e		4 Donation 5 Other (Specify) Moses C	ematory or other place) Semetery 8-22	2-06 D	rury, Mo	
Ball	permit. Page Department of Important: If any injury or		Larry D, Delse 11100783 8	2. Name and Address of Facility M. Reese & Mort 21 West St. Anr	lapolis,	Ma. 214	
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a End Stage (ther the mode of dying, such as cardiac renal discease		ŧ,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a color of):				U
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
o,	ate be executed hysician and the burial-transit	i Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				
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Box	he death certificate the attending phys ched for use as the	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	olivery Day Year
ds, P.O.	uires that the di signed by the id be detached	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part 1.			o the cause of death?
Records,	The law requires that the ate has been signed by the page 2 should be detache	Completed			24a. Was an autopsy performe	prior to	
Vital		Be C	25. Was case referred to medical examiner?		th (Check only one)		
o	ing Phys After this uneral di	tlon: To	1 Yes 2 Pending 2 Accident		ome 5 Residen 28d. Describe how	ce 6 Other (Speringly occurred	ecify)
Division	al or Attending after death. I Director: After d in by the funer	ertification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	eet and Number or F State)	iural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C	29a. Certifier (Check only one) 1 Sertifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or is and manner stated.	ath occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the cau rred at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
)	To the To the comp	W	29b. Signature and title of certifier MD	29c. License number		d. Date signed (Mon $3 - l 7 -$	
	il	£.	30. Name and address of person who completed cause of death (Item 23a) (Type	2) 50 7 c	1. Idans	Then	DIINO
F 16	Sta		31. Date filed (Month, Day, Year) 33. Jegistrar's Signature	Laste 1	, vois V	we re	3 41108
9.5	Registi	ar	AUG 2 1 2006				

State of Maryland / Department of Health and Mental Hygiene 006 28364 State Registrar AMEND#16operFH8/23/06,BMW,MoCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** August 18, 2006 8:50 P. Juanita Rogers Reutlinger /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛱 F 83 577-34-3213 Director June 8,1923 Virginia Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at Maryland 1X Yes 2 No Montgomery Kensington Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 9623 Hawick Lane 20895 United States death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White δ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Medical Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event once. Be William Rogers Rache1 J. Harless 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ruth Dudley/ Daughter 15105 Cosmos Court, Rockville, MD 20853 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Georgetown University August 20 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licenses 22. Name and Address of Facility Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician <u> Inferior Mesentary Ischemia</u> /Medical Due to (or as a consequence of): Examiner Mesentaric Ischemia and Mesentaric Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Small Bowel Perferation and Abscess and Due to (or as a consequence of): the attending physicien 68760 Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) O 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ cate has been signing page 2 should be Short Bowel Syndrome 1 → Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Myocardial Infarction autopsy performed? Peripheral Vascular Disease 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🖳 No (A) 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Vision of V Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🖾 Inpatient Certification; To 1 ☐ Yes 2 🔯 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 within 24 hours a 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 18, 2006 D0054299 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road 20814 Bethesda, MD Eric Brodsky, M.D. 31. Date filed (Month, Day, Year) 32/Registrar's Signature State **AUG** 23

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Registrar

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JUANIL

FUTLINGER

State of Maryland / Department of Health and Mental Hygien 2006 28365 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 23, 2006 ear **Physician** 2:55 AMM Rankin Robert /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Citizens Care and Rehab. Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**X** M 2 ☐ F Maryland 89 365-10-3196 **Director** April 1, 1917 Usual Residence of Deceden death with the Maryland 10d. Inside City Limits 10a, State 10b. Count 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Heatilt and Mental Hygiene.
ant: if item 27 is marked other than "naturat", or items 23a or 28a-1 show ury or other traumatic event, its Muckal Extinition man be notified as ury or other traumatic event, its Muckal Extinition man be notified as 1 ☐ Yes 2 No Maryland Frederick Frederick Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21702 USA 1004 Young Place Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 ☐ No Specify. Baltimore, Maryland 21215-0036 Specify. ٥ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) Sales Manager 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Knutzen Rankin Charlotte James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1004 Young Place, Frederick, MD 21702 Robert R. Rankin/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o important; if eny injury or once. Frederick Crematory Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 8/24/2006 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signature of Funeral Service License 1621 Opossumtown Pike, Frederick, MD 21702 Approximate Intervat Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use es the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes hes been signed and been signed to should be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 Y No 24a. Was an autopsy performed r this certificate he rai director, page ? 1 Yes or Attending Physician: Be 25. Was case referred to medicat 26. Place of Death (Check only one examiner' Hospital: Other: 1 Yes 2 € 1 🗌 Inpatient ပ 2 ER/Outpatient 3 DOA 4√ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how intury occurred Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No Director; 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗍 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and or eyestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and an D-13971 06 cause of death (Item 23a) (Type, Print) 30 Name and address of person who compl \vee_{MD} 300 West 9th Street, Frederick, MD 21701 Robert Kaufmann, 32. R gistrar's Signature 31. Date filed (Month, State Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 28366 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 **Physician** James A. Rice August 22, 1:15 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Frederick Glade Valley Nursing and Rehab Walkersville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1₩ 2□F Yrs. Director 215-18-1102 81 January 13, 1925 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f ahov The Madical Examiner must be notified at Maryland Frederick Walkersville ty⊟Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21793 300 Chapel Court USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1⊠Yes 2□No 1943 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Specify δ 1945 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) other than College (1-4or 5+) Cartographer map maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fill ment of Health and Mental Hant: If Item 27 Is marked other Howard D. Rice, Sr. Ida V. Shaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chad Weddle p grandson 69 W. Frederick St., Walkersville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. 8-26-2006 Walkersville, Maryland Glade Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home raron lue 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Preumaria ASPIRATION Physician disease or condition resulting in death) 20 Minuts /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by GASHOESOPHAGEOL 1 Yes 2 No 3 Probably 4 Denknown been si Completed PARKINSONS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 10 No certificate Hypertension 2□ No 1 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c, Injury at Work? 27. Magner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospitel within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. of certifier 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D40307 asuci 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) 1564 Opossumtown Pike, Frederick, Maryland B. Casagrande, M, D. Eugene 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 4 2006

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Registrar

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	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of De	
120			Holy Cross Hospi	tal		Silver	Spring		Mor	ntgomery
	Funeral Director	f	212-14-5969	7. Age ((In yrs. last birthday) 5 Yrs.	If Under 1 Year Months Days	II Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec. 23	, Year) 9. E	sinhplace (State or Foreign Country) Lrginia
	tryland show		Usual Residence of Decedent 10a. State 10b. County	1	IOc. City, Town or Lo	cation				10d. Inside City Limits 1 □ Yes 2 No
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21215-0036	s 1 and 2 should be tiled within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or Iteme 23a or 28a-f show other treumatic event, the Medical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	1	Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2⊠ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi Specify: Wh	
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Maryland	should be til ind Mental H is marked oth umatic even	To Be	17. Father's Name (First, Middle, Last) Fred H. Knight					e (First, Middle, _e B. Se	Maiden Sumame) al	
	and 2 sho ealth and ! n 27 is ma		19a. Informant's Name/Relationship (7 Eugene T. Knight/	,, ,					r, City or Town, State ng, MD 209	
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place of Dispo cemetery, cren Meadowridge	natory or other plac	Augu	Date ist 26	20c. Location - City	
Balt	permit. Page Department of Important: if any injury or		21. Signature of Funeral Service Licens	900 Q					Home Inc. lver Sprin	ng, MD 20901
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	To the Hospital within 24 hours a To the Funerel Completely tilled	edical	29a. Certifier 1 Certifying Phy (Check only one)	vsician: To the best of iner: On the basis of e and manner state	xamination and/or in	occurred at the time vestigation, in my op	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier			29c. License	number	ż	29d. Date signed (Mo	nth, Day, Year)
			> Chrita-			D32	332		August 2	20, 2006
0 (2-		30. Name and address of person who c Suresh Gupta, M.D				, Silver	Spring,	MD 20902	
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Exami Funeral Director	ner	4a. Facility Name (If not institution, give st Laurel Regional 5. Social Security Number 6. Sex	Hospital 7. Age (In yrs. Ia.	st birthday) Yrs.	Laure If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, 11 1 - 20 -	Year) 9. Bi	ath George's Thiplace (State or Foreign Country) nchburg, VA
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1		30. Name and address of person who cor	npleted cause of death (Item	23a) (Type,	Print) CELLYC	o Mo	2070	7	
St Regis	ate	31. Date filed (Month, Pay, Year) 4 2	006 Reserve	IF A	perce				

State of Maryland / Department of Health and Mental Hygieney 28369 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician August 18 2006 Thomas Wesley Ross 1010 /Medical 4a. Facifity Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Laurel Regional Hospital Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, YOct. 24 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year **XX**M 2□ F Yrs 71 1935 Maryland Director 217-30-6926 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State in then "neturel", or items 23a or 28a-f show the Medical Exeminer must be notified at 1 XYes 2 No Maryland Prince George's Laurel Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11434 Laurel Bowie Road 20708 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If Item 27 Ie marked other then "neturel", or Items 23. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 27 No If Yes, Give Year or Dates: 1 Never Married XXMarried Baltimore, Maryland 21215-0036 1 Yes 25 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th 0 Supervisor City of Bowie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Beatrice Watkins George R. Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11434 Laurel Bowie Rd. Laurel, Md. 20708 Margaret Ross (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Md. National Mem. Park PEBurial 2 Cremation 3 Removal from State permit. Page Depertment of Importent: If eny injury or ong injury or 8/23/06 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Reese & Sons MOrtuary West St. Annapolis, M Wm. 821 MO0483 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebral Thrombosis minutes /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto (or as a consequence of). Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Dav Year Month 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pneumonia Aids 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed this certificete has been ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an performed? Yes 25 No 1 Yes Director: After this certific I in by the funeral director, Be 25. Was case referred to medical 26. Place of Death Check only one 1 Minpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₺ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No М investigation 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, faclory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide or A To the Hospitel (within 24 hours at To the Funeral Di Entitying Physician: To the best of my knowledge, death occurred at the firms, date and place, and due to the cauca(c) and manner so stated. 29a Cartifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 20, 2006 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 5

DHMH 17 Rev 1/2001

State

Registrar

William A.

31. Date filed (Month, Day, Year)

Warren

AUG 2 2 2006

ORIGINAL

Registrar's Signature

321 Prince George St. Laurel, Md. 20707

			1 - For State Registrar	State of	Marylar	nd / Depa <i>Cei</i>	artment o rtificate	f Health of Deat	n and M th		giene Reg. No		28370
	Physici	20	1. Decedent's Name (First, Middle, Las	st)						2. Date of De Month	ath Dav	y Year	3. Time of Death
	Physici /Medio		Evelyn Edith Stepp	er						8/20/2	2006	, , , , , , , , , , , , , , , , , , , ,	12:20 P M
	Examir	er	4a. Facility Name (If not institution, give		nber)		4b. City, Tow		on of Death		4c.	. County of Deat	
			4705 Arbutus Avenu 5. Social Security Number 6. S		7. Ago //g.um	last hirthday	Rockvi		der 24 Hrs.	O Date of Di-		Montgo	
Ċ	Funeral Director			□M 211 F	7. Age (<i>In yr</i> s. 84	Yrs.	Months Da			8. Date of Bir (Month, Da 9/20/1	tn ly, Year) L921	9. Birt Co	hplace (State or Foreign untry) PA
	land w		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	Many	tor	MD Montgome	erv	R	ockvi1	l e						1 ∰Yes 2 ☐ No
	h the	irec	10e. Street and Number				10f. Zip Coo	le			10g. Cit	izen of What Co	untry?
	238 c	aiD	4705 Arbutus Avenu	ie			20853					United	States
336	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 ie marked other then "naturel", or items 23e or 28e-1 ehow many luty or other traumatic event, Ita Medical Exartina must be notified at announce.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 🎇 Divorced	12. Was Dece Armed For 1 Yes If Yes, Give Year or Da	ces? 2 🏹 No e		Was Decedent f Yes, specify (1 ☐ Yes 2 💢	Cuban, Mexi	can, Puerto I	cify Yes or No Rican, etc.)	-	14. Race - Ame Black, White Specify: Wh	
ŏ	2 ho	ted	15. Decedent's Ed	lucation		16a. Dece	dent's Usual Oc	cupation			16b. Ki	ind of Business/	
21215-0036	d within 7 piene. r then "n ir e Med	Completed	(Specify only highest gra	College (1	-4or 5+)	Secre	kind of work do DO NOT use re etary	ne during m tired)	ost of workii	ng .	US (Governme	ent
b	al Hyg	BeC	17. Father's Name (First, Middle, Last)					18. Mo	ther's Name	(First, Middle,	Maiden	Sumame)	
<u>Ja</u>	Menta Menta Prked	To	Nathan J. Alegand					Ida	Cher	ry			
Maryland	nd 2 sho alth and 27 le m		19a. Informant's Name/Relationship (19a Harold Stepper - S			19b. Mailir 12700	ng Address (Str) Veirs	eet and Nun Mill	Road	Route Number 2 Rock	er, City o	r Town, State, Z Le MD 20	(ip Code) 1853
ore,	of He of He of He of He	14	20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 💆	Domayal from 6		Place of Dispo	sition (Name or natory or other	place)	D	ate	20c. Lo	ocation - City or	Town, State
Ě	Pan ment		4 □ Donation 5 □ Other (Specify		1	ng Davi	id Memo:	rial	8/2	3/2006	F.s	alls	Church VA
Baltimore,	Dependit Import		21. Signature of Funeral Service Licen	See		-	Name and Ad		cility Edwa	ard Sa			l Direction
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that ca	used the deat								Approximate Interval Between
ı	Physician		Immediate Cause (Final disease or condition	a	C	olon Ca	ancer					4	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):							
		_	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	mence of):							
	rted nsit	nine	Cause (Disease or injury	20010(or us a conseq	derice or).							
oʻ	ficate be executed physicien and is the burial-transit	dical Examiner	that initiated events resulting in death) Last	Due to (c	or as a conseq	uence of):							
8760,	ate be hysici	lcal		d									
Φ	certific nding p	//Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregna	ancy						23d. Date of deli	wasi
.O. Box	that the death certifined by the ettending detached for use as	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ZÃNo 9 ☐ Unknown		rth 2∐Feta ant at time of d wn		Ectopic pregna Other (specify					Month	Day Year
ds, P	9 20		Part II. Other significant conditions or	ontributing to de	ath but not res	ulting in the ur	nderlying cause	given in Pa	rt I.		obacco u /es 2(the cause of death?
COL	w requir been si should	lete								24a. Was		-	topsy findings available
Division of Vital Records,	The ste h page	Completed								autop perfo		prior to death?	completion of cause of
/ita	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?						ace of Death	Check only o	Λ		
) 	9 0 =	٥	1 ☐ Yes 2 ☑ No			ER/Outpatien	3 DOA					6 ☐Other (Spec	cify)
u C	P fee	ion	27. Manner of Death 1 XNatural 5 Pending		n, Day Year)	28b. Time of Injury		Vork?		8d. Describe h	now injur	y occurred	
S	Attending ir death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be	-	of Injury - At he	ome farm str	et, factory, offi	Yes 2		Rf Location /5	Street an	d Number or Ru	ral Route Number.
2	iel or Attending Phy s after death. al Director: After this ed in by the funeral d	Certification:	4 Homicide determined	buildin	g, etc. (Specif	y)	ooi, lactory, on			City or Tov			rai riobie ivanibei,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical (29a. Certifier (Check only one)	ysician: To the liner: On the ba	best of my kno sis of examina er stated.	wiedge, death ition and/or inv	occurred at the restigation, in m	time, date y opinion, d	and place, a leath occurre	nd due to the	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of contifier				29c. Lice	ense numbe	er		29d. Dat	e signed (Month	
1	10		人女人	1	_ ~	4	D35	5635			Αυ	gust	21, 2006
	(~		30. Name and address of perso door Joseph Kaplan MD	completed cause	of death (Item rince F	23a) (Type hilip	Print) Drive S	uite	327 01	ney MD	208	32	
	Sta	e	31. Date filed (Month, Day, Year)										
	Registr		AUG 2 3 20	U6 Se	gistrar's Signa	. 000							

			1 - For State Registrar	State of	Marylar	nd / Depa <i>Cei</i>	artmer	t of H	ealth a	and M	lental Hy	gien Reg. No	2006	2837	/
		П	1. Decedent's Name (First, Middle,	Last)						-	2. Date of De	aath		3. Time of Dear	th
	Physici /Medio		Arnold Shakhma	an								17,	2006	9:24 A	М
	Examir		4a. Facility Name (If not institution,	give street and numb	er)		4b. City,	Town, or	Location of	of Death		40	c. County of De	ath	
			10250 Westlake I					esda		0411			lontgome		
ш	Funeral Director			6. Sex 7. 1XIM 2□F	Age (In yrs. 85	last birthday) Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da 7-28-1	rth a <i>y, Year</i> O 2 1	9. Bi	rthplace (State or For	eign
			215-25-5149 Usual Residence of Decedent		- 05						/-20-1	921		kraine	
	nylanc how		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Lin	nits
	8a-1.	cto	MD Montgo	mery	Bet	hesda								13€ Yes 2 □	No
	ith th	Director	10e. Street and Number		01/		10f. Zip						itizen of What C	ountry?	
	s 23a	ra	10250 Westlake					317	1100000						
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than *natural*, or Items 23e or 28e-f show mortal right or other traumette event. It is Middell Examitant maint is mortified at Apprex.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Deceded Armed Force ed 1 🔯 Yes 2 If Yes, Give Year or Date	es? □No	1	Was Deced fYes, sped I ☐ Yes		spanic Ori n, Mexican Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Am Black, Wh Specify: W	te, etc.	
ဝို	2 hou	ted	15. Decedent'	s Education		16a. Deced	dent's Usu	al Occupa	ıtion			16b. k	Kind of Busines	s/Industry	
Baltimore, Maryland 21215-0036	d within 7. piene. r than "n tre Medi	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4	or 5+)	lifel	kind of wo DO NOT u ngine	se retired,	lu <i>ring</i> mosi)	t of worki	ing		overnmen	,	
힏	al Hyg	BeC	17. Father's Name (First, Middle, L								(First, Middle		n Sumame)		
yla	Ment Ment arks etics	To	Greg Shakhma	an					Rose	≥ "Uı	nknown"				
, Mar	and 2 she baith and n 27 is m or traum		19a. Informant's Name/Relationsh Rachel Abramson		r						il Route Numb Chesda,		or Town, State, 20817	Zip Code)	
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from Sta		Place of Dispo cemetery, cren	sition (Nar natory or o	ne of ther place	9)		Date	20c. L	ocation - City o	Town, State	
Ē	tant:		4 ☐ Donation 5 ☐ Other (Sp	ecify)		rklawn	Memo	rial	8	-18-	-06	Roc	kville,	MD	
Ba	permit Depar Impor sny in		21. Signature of Funeral Service L	icensee									e, MD 20	ipels, Inc 0852	•
	Pnysician		23a. Part1. Enter the disease, of c shock, or heart failure. List o Immediate Cause (Final disease or condition			h. Do not ente			, such as	cardiac	r respiratory a	rrest,		Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	a	as a conseq										
	Examiner	_	Sequentially list conditions,	_{b.} Hypert	ension										
	ted nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			ructiv	е 1пт	ng Di	sease	e					
<u>,</u>	execun n and ial-tra	Examiner	that initiated events resulting in death) Last	C	as a conseq										-
8760,	icate be executed physician and s the burial-transit	dlcall		d											
မ	ng ph	Jedi	IF FEMALE:												
D. Box	ie death certificate be executed the attending physician and hed for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	n 2 ∏ Feta tat time of d	Ideath 3□	Ectopic pr Other (sp						23d. Date of de Month	livery Day Year	
P.0.	that the dended by the a		Part II. Other significant condition	s contributing to deat	h but not res	ulting in the ur	iderivina c	ause give	n in Part I.		23e. Did t	obacco	use contribute t	o the cause of death?	
rds,	sign along	Completed by	Coronary Art											robably 4 □Unkno	
Seco	S S D	nplet		· · · · · · · · · · · · · · · · · · ·							24a. Was	DSV	24b. Were a	utopsy findings availa completion of cause	ble of
a	ilcian: The li certificate ha rector, page ?			_								rmed? 200 No	death?	3 2 □ No	
₹		o Be	25. Was case referred to medical examiner? 1 Tyes 2 X No	Hospital:		FD/0		Othe	_		Check only o		TEXT DIE		-
ō	g Phys er this eral dii	ت: <u>آ</u>	27. Manner of Death	28a. Date of I (Month,		ER/Outpatient 28b. Time of		8c. Injury Work	4 🗀 Nui		ne 5 Resi		6 □Other (Spe	icify)	
<u></u>	Attending or death.	atlo	1 Natural 5 Pending 2 Accident investiga		Day Year)	Injury	м		? 'es 2 □ N	No			,		
Division of Vital Records,	2 2 2 4	Certification;	3 Suicide 6 Could no 4 Homicide determin	28e. Place of	Injury - At ho etc. (Specify	ome, farm, stre	eet, factory	r, office		2	28f. Location (S City or Tox	Street an	nd Number or R e)	ural Route Number,	- Y
	To the Hospital within 24 hours a To the Funeral Completely filled in	edical (29a. Certifier 1⊠ Certifying (Check only one) 1 ☑ Certifying 2 ☐ Medical E	Physician: To the be xaminer: On the basis and hapner	s of examina	wledge, death tion and/or inv	occurred estigation,	at the time in my op	e, date and inion, deat	d place, a	and due to the ad at the time,	cause(s date and) and manner a d place, and du	s stated. e to the cause(s)	
	To the within 2 To the comple	M	29b. Signature and title of certifier	MI				License					ite signed (Mon		
			•	1/10/			I)4636	4			Aug	g. 17, 2	2006	
_			30. Name and address of person was Dr. Felix Sokol	no completed cause of sky 11125	of death (Item Rockvi	23a)(Type, F Llle Pi	ke St	ie. 2	203 R	ockv:	ille, M	D 20	0852		
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 3		strar's Signa	ture	and s	Š.							

			1 - For State Registrar	State of M	arylan	id / Depa	artme <i>rtifica</i>	nt of H	ealth a Death	and N	lental Hy	giene Reg. No2 (006	283	372
ı	Physici /Medi		Decedent's Name (First, Middle, La Myer Max	SEROTA						_	2. Date of De August		06 ^{Year}	3. Time of 9:34	
	Examir		4a. Facility Name (If not institution, giv Washington Advent						Location o	of Death			nty of Death		
	Funeral Director			Gex 7. Aç IM∑M 2□F	89	last birthday) Yrs.	If Und Month	or 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir Augonth./Pa	th 19917		place (State o	or Foreign
	Maryland a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Prince (Georges		y, Town or Lo	cation							10d. Inside C 1 🏋 Yes	ity Limits
	th with the 23a or 28	Funeral Director	10e. Street and Number 2302 Muskogee Sti	eet	1		10f. Z	ip Code 2078:	3			10g. Citizen o		ntry?	
9000	be filed within 72 hours after death with the Maryland ital Hygiene. Ital Hygiene. It is matural; or iteme 23e or 28e-f ehow event, it e Medical Exercitor invalue to rediffed al	Ď.	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Way Yes 2 ☐ If Yes, Give Year or Dates	•			edent of Hi ecify Cuba 2 X No	spanic Orig n, Mexican Specify:	jin? (Sp , Puerto	ecify Yes or No Rican, etc.)	14. R B	ace · Americack, White,		
Maryland 21215-0036	filed within 72 h Hygiene. other than "natu ent, tre Madiral	Completed	15. Decedent's E. (Specify only highest grade Elementary/Secondary (0-12)	ducation		16a. Deced	kind of w		urina most	of work	ing	16b. Kind of		•	
yland	should be file nd Mental Hy marked oth matic event	To Be (17. Father's Name (First, Middle, Last, Abraham Serot	a					18. Mothe Ros		e (First, Middle, T i plisk		ame)		
	permit. Pages 1 and 2 should b Department of Health and Mente Important: If item 27 is marked any injury or other traumatic e once.			Type, Print) spouse					St.,		phi, MI				
Baltimore,	Pages 1 tment of H tant: If its		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	y)	Mt .	Place of Dispo emetery, cren Lebano	natory or On Ce	other place emeter		ug.2	0, 200	_	hi, M	D	
Bal	Depar Depar Impor any In		21. Signature of Fune/all Service Licer August 23a. Part1. Enter the disease, or com	12/1		2.5	54 Ca	rrol.	L St.	, NW	chinsky , Wash	ington			ome
8760,	death certificate be executed Wedical We ettending physician and e ettending physician and od for use as the buriat-transit	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated eyents resulting in death) Last		stati a consequ	uenes of):	state	e Cano	cer					Interval Bet Onset and I	Death
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rds, P.	tw requires that s been signed I s should be det	þ	Part II. Other significant conditions of Stroke	ontributing to death b	ut not resu	ulting in the ur	nderlying	cause give	n in Part I.			obacco use co			
al Reco	: The law requires that the cete has been signed by th page 2 should be detache	Completed	Hypertension								24a. Was autop perfor	rmed?	prior to cor death?	psy findings ampletion of ca	available ause of
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 1월 Natural 5 ☐ Pending 2 ☐ Accident investigation	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da	ry	ER/Outpatient 28b. Time of Injury		28c. Injury Work	r: 4 🗆 Nur:	sing Hor	n <i>Check only</i> on the 5 ☐ Resid 28d. Describe h	lence 6 🗆 Ot		y)	
Divis	al or Atte s after des al Director ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc	ury - At ho c. (Specify	me, farm, stre	et, facto	y, office		- 1	28f. Location (S City or Tow	Street and Num n, State)	iber or Rura	l Route Num	ber,
	To the Hospital within 24 hours of To the Funeral completely filled	edical	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of tiner: On the basis of and manner sta	examinat	wledge, death ion and/or inv	occurred	at the time	e, date and nion, death	place, a	and due to the ded at the time, d	cause(s) and made	nanner as st , and due to	ated. the cause(s))
ť	To the complet	Σ	29b. Signature and title of certifier	Sa Sa		Sal 1	1/4/8	c. License 06035				29d. Date sign August			
1			30. Name and address of person who sean S. Saedi, Mi	11120	New F	Tampshi		we.,	#305 Silv	er S	pring,	MD 209	904		
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 3 2	006 32. egistra	r's Signat	y. So	well								

			For State Registrar	State of I				of H	ealth a		_	vaiene		106	28373
	Physici	an	1. Decedent's Name (First, Middle				imouto				2. Date of D Month 08			Year	3. Time of Death 12:23 P M
	/Medic Examin		Eunice R. B. 4a. Facility Name (If not institution National Luthe	. 0					Location o			-	County	of Death	
	Funeral Director		5. Social Security Number 578–36–0550	6. Sex 7.	Age (In yrs.	last birthday) Yrs.	If Under 1		If Under 2		8. Date of B (Month, D 1-23-1	irth Day, Year) 910	HOL	9. Birthp	lace (State or Foreign
	aryland show	<u>.</u>	Usual Residence of Decedent 10a. State 10b. County			y, Town or Lo	cation							1	0d. Inside City Limits 1¥⊆Yes 2 ☐ No
	vith the M or 28a-1	Directo	10e. Street and Number	gomery	Roc	kville	10f. Zip (10g. Citi		What Cour	
36	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show ha Modical Examiner must be notified at	y Funeral Director	9701 Veirs Drive 11. Marital Status 1 Never Married 2 Marrie	12. Was Decede Armed Force 1 Yes 2 If Yes, Give	s? Š∏No	1	2085 Was Decede f Yes, specif	ent of Hi		gin? (Spec , Puerto F	cify Yes or N Rican, etc.)		Bla	e - Americ ck, White,	etc.
21215-0036	thin 72 hours e. an "naturel", Modice Ex	Completed by	3 ☐ Widowed 4 ♣ Divorced 15. Decedent (Specify only highes Elementary/Secondary (0-12)	Year or Date		16a. Deced (Give life. I	dent's Usual kind of work DO NOT use	l Occupa k done d e retired,	ation	of workin	99	16b. Ki	nd of B	Whit	dustry
and 21	e filed Il Hygi other vent, I	Be	17. Father's Name (First, Middle, Walter Arthur B	í		Gen	ealog:	ıst			(First, Middle	e, Maiden	Suman		stry
Maryland	and 2 should be eaith and Mental m 27 is marked one traumatic every	2	19a. Informant's Name/Relationsh David Scribner,	nip (Type, Print)					and Numbe	r or Rural	Russel Route Numi York,	ber, City o	r Town,	State, Zip	Code)
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menia Important: If item 27 is marked any injury orighter traumatic events.		20a. Method of Disposition 1 □ Burial 2 ☼ Cremation 4 □ Donation 5 □ Other (St	3 ⊠Removal from Sta		Place of Dispo emetery, cren ional	sition (Name	e of her place	e)		ate	20c. Lo	cation -	City or To	
Balt	permit. Departr Import any inji		21. Signature of Fun-al Service I			1	091 R	ockv	ille	Pike	Rocky	ville			
	executed /Medical /Medical /Medical / Examiner	Examiner	23a. Part1. Enter the disease, or shock, or heart failere. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying and Ches	auu to (or buu to (or c.	ı line.	vance of):	-	Cor dying	f L	all	we Der	rrest,	X;	4	Approximate Interval Between Onset and Death I Week
O. Box 68/60	death certificate be e attending physicia d for use as the bu	Physician/Medical B	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	d. 23c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknown	2 ☐ Feta at time of d	Ideath 3□	Ectopic pre					2	3d. Da Mo	te of delive	ry Day Year
rds, P.	law requires that the de as been signed by the 2 should be detached	by	Part II. Other significant conditio	ns contributing to death	but not resi	0 //	nderlying car	-	in in Part I.	ceré		tobacco u Yes 2			e cause of death?
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or Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpa		ER/Outpatien		-	4 D ur	sing Hom	(Check only ne 5 ☐ Res	idence 6)
VISION	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	27. Mann Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n 4 Homicide determine	ation ot be 28e. Place of	Day Year)	28b. Time of Injury	М		at ? ∕es 2 □ N	10			d Numb		l Route Number,
5	ospital or hours afte uneral Dir y filled in	al Ceri	29a. Certifier 1 Certifying	g Physicien: To the be	st of my kno	wledge, death	occurred at	t the time	e, date and	d place, a	nd due to the	cause(s)	and ma	nner as st	ated.
	To the He within 24 To the Fu	Medical	(Check only 2 Medicel E one) 29b. Signature and title of certifier	examiner: On the basis and manner	stated.	tion and/or inv			number	h occurre	d at the time				Day, Year)
ì	v		30. Name and address of person v	who completed cause o	COLS f death (Item	23a) (Type, I	Print)	17	4170	46		Hug	US	16/	2006
	Sta Registra		Charles W. Kar 31. Date filed (Month, Day, Year) AUG 23	2006 32 legi	033 Ri strar's Signa	dge Rd	Dam:	ascu	ıs, MD	208	72				

State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registrer Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DOROTHY CATHERINE STUP August 2008 9:50 /Medical 4a. Facility Name (If not institution, give street and number)
Tranquility at Frederick 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Months Days Hours Min. 0 ct. 18, 1908 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 215-74-5540 1 M 2 F 97 Mary Tand Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 Tyres 2 □ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 Mercer Place Suite 11-5 21701 U.S.A. Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 ☑ No 3 Widowed 4 □ Divorced Specify: White 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than *r any injury or other traumatic event, the Med any injury or other traumatic event, the Med any once. Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Russell Dorsey Margie Albaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne D. Dietz / Daughter 906 Seminole Road, Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery 8/25/06 `4 □ Donation 5 □ Other (Specify) Frederick, Maryland ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part 1. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on or ch line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cordio Versula Deser Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (alice to list and a finite property) Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or injur that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. the þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2XINo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b rector, page 2 s 24a. Was an autopsy performe 20] No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) 45515/44 examiner' Other: 4 Nursing Home 5 Residence 2 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of pertifier 29d, Date signed (Month, Day, Year) d cause of death (Item 23a) (Type, Print) 30. Name and address of person who 300 W. Ninth St. Frederick stmann State Registrar

State of Maryland / Department of Health and Mental Hygien 2006

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			1 - State Registrar		•	Cei	rtificate	e of E	Death		Reg.	No.	0.0	20310
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Baltimore,	permit. Pages 1 Department of H Importent: If Ite any injury or otl		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		20b. Place ceme HILLSI CHURCI	of Dispo tery, cren BORO H_CEN	sition (Nam natory or ott EPIS(METERY	e of her place COPAI Y	9/	Date 15/2006	_		City or Tov	MARYLAND
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ı			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lin	the death. D	o not ente	er the mode	of dying,	such as cardi	ac or respirato	ry arrest,			Approximate Interval Between
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9 x	ertificate be executed ding physician and se as the burial-transit	Medical	IF FEMALE:									Τ		
.O. Bo	death of attented for us	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pre Other (spe				_	23d. Dai Mo	e of deliver nth [y Day Year
Φ.	requires that the een signed by th hould be detache		Part II. Other significant condition	ns contributing to death bu	ut not resulting	in the un	nderlying ca	use given	in Part I.	23e. E	oid tobacc	o use cont	ribute to the	cause of death?
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Vital		e Co	25. Was case referred to medical							1 □ Ye	s 2 9		☐ Yes 2	2 □ No
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	To the Hospital or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical one)	Examiner: On the basis of and manner sta	examination a	ind/or inv	estigation, i	n my opin	ion, death occ	curred at the tir	ne, date a	and place, a	and due to t	he cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certified	Milde			29c.	License r	number				(Month, D	
			1/3	12/				170	3933	5		8.25	5.06	
	0	-	30. Name and address of person	who completed cause of de	eath (Item 23a) (Type. F	Print)	/			•			
,	3 -	20	MD Crowle 31. Date filed (Month, Day, Year)	y MD	S/O Z	nto	lima	215 L	ane,	Eas;	ton	M	ZIC	501
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006

1- State Amend item#28a,28d-f,pen/E,g859,9/18/06 The left of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SWANSON **Physician** Month Year ChARd 1:25 Aug 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Specially Baltimore Hospital Baltimor If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day, 6. **\$ex** 5. Social Security Number ~ Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 222-36 1**X**M 2□ F Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location or 28a-f show traumatic event, the Medicul Evaruinar must be notified at BALtimore ltimore Director 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2123 items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Pages 1 and 2 should be filed within 72 hours aftenent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or i Completed by 1 ☐ Yes 2 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HANdy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SWANSON MARUIN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JUNE Important: If iten any injury or othe once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Silverbrook Cem. permit. Page Department 8/31/06 Wilmington *4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Ligersee FUNERAL HOME CONGO. 22. Name and Address of Facility 201N. GRAYAVE, Wilmington, DE 19805 23a. Part1. Enter the disease, or complications that carried the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2085 /Medical Due to (or as a insequence of): **Examiner** Decubitus U/Cers Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit Due to (or as a consequence of): Be Completed by Physician/Medical 3 Ectopic pregnancy
5 Other (specify) IF FEMALE: N A 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Quadrip 2 No. 1 ☐ Yes 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Direct 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D0050480 traung 08/22/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZERA-YOHANNES, 601 South Charles Street, Baltimere, MO 21230 31. Date filed (Month, Day Year) AUG 2 4 32. Segistrar's Signature

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 200528377 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yeer **Physician** Cora B. Sacco August 2006 4:35 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 13351 Triadelphia Mill Rd Clarksville Howard 5. Social Security Number f Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 7. Age (In vrs. last birthday) Funeral Birthplece (State or Foreign Country) Days Hours 1 □ M 2 □ XT Director 214 18 8895 86 13, 1920 | West Virginia Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show aust be notified at 1 ☐ Yes 2 🙀 No Director MD Howard Clarksville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 13351 Triadelphia Mill Rd or items 23a 21029 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2127 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: 3 Widowed 4 □ Divorced Year or Dates: "natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry Elementary/Secondary (0-12) rthan College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: if Item 27 is marked other eny injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Franklin Floyd Hovermale 2 Edith Eve Euens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet L. Wentzel/Daughter 9826 Diversified Lane Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 8-23-2006 Catonsville, MD 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee /M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as 1 consequence of): **Examiner** Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): as the burial-Box 68760. the attending physician Physician/Medicai IF FFMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetel death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9□ Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. \$ 3 Probably Completed 1 Yes 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? this certificate 1 ☐ Yes 2 💯 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check onlone Hospital: Jo 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 COther (Specify) roup home 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification; After 5 Pending investigation 1 XNatural within 24 hours after
To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of cert 29c. License numbe 29d. Date signed (Month, Dey, Year) 30. Name and address of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State of Maryland		artment of F		Mental Hygie	ZIIIIb	28378
ľ	Physici /Medic		1. Decedent's Name (First, Middle, Last) Effie Scott						Day Year 1 2006	3. Time of Death 10:40A M
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	3e or 28a-	Funeral Directo	10e. Street and Number 164 Chestnut St			10f. Zip Code 21222	-	10g.	Citizen of What Co	ountry?
036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any fujury or other traumatic event, the Medical Examinar must be notified at ADEs.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 PNo If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? In, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit Specify: B1	e, etc.
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Baltimore,	. Pages 1 tment of He tent: If Iten jury or oth		20a. Method of Disposition A Burial 2 Cremation 3 A 4 Donation 5 Other (Specify)	emoval from State Par	emetery, crer stgat k	sition (Name of natory or other place Mem.	8/2	22/06 Ar	Location - City or	
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rds, P.O.	w requires that the de been signed by the a should be detached t	ρ	Part II. Other significant conditions cor	ntributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tobace		o the cause of death?
al Reco	: The law recate has bee	Completed						24a. Was an autopsy performed 1 Yes 2 1	death?	atopsy findings available completion of cause of
of Vita	g Physician: T er this certificat eral director, pa	n: To Be	27. Manner of Death	lospital: 1 Inpatient 2 I	28b. Time o		er: 4 🗆 Nursing	Home 5 Residence 28d. Describe how		City) BESIDEACE
Division of Vital Records,	il or Attending F after death. I Director: After d in by the funer	Certification:	1 Matural 5 Pending 2 Accident 3 Suicide 6 Could not be 4 Homicide	28e. Place of Injury - At ho building, etc. (Specify	Injury me, farm, str	M 1	Yes 2 □ No	28f. Location (Stree City or Town, S		ural Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	dical	(Check only 2 Medical Examinate)	sician: To the best of my knowner: On the basis of examinat and manner stated.	tion and/or in	vestigation, in my o	pinion, death oc	curred at the time, date	and place, and due	to the cause(s)
)	To the within To the compl	Me	29b. Signature and title of certation	in mp		29c. Licens	e number	29d.	Date signed (Mont	h, Day, Year)
	5		29b. Signalure and title of certifier 30. Name and address of person who co 31. Date filed (Month, Day, Year) AUG 2 2 20	empleted cause of death (Item	23a) (Type,	Print) DR, A	lan i	MR 155	(A	convercy
DH	Sta Registi MH 17 Rev 1/2	ate rar	AUG 2 2 20	06	* A	ack)				

ORIGINAL

For

22279

Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "naturel", or Iteme 23e or 28s-f ehow eny Injury or other traumatic event, Ite Medical Examination must be motified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate hes been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

		- State Registrar			Cert	ificate	of E	Death			Reg. Ne	یک ل	V O	20313
	_	1. Decedent's Name (First, Middle, L	_ast)							2. Date of De	0	av.	Year	3. Time of Death
sicia edica		PATRICIA DIANNE	SWANN							AUGUST	22	2, 2	20 0 6	4:18 P M
mine		4a. Facility Name (If not institution, g				4b. City, T LA	own, or PLA		of Death		40	CHA	of Death	
ral or		5. Social Security Number 6. 219–48–4663		(In yrs. last	birthday)_ Yrs.	If Under 1 Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Bir	r 16	,1948	9. Birthp	lace (State or Foreign
	ŀ	Usual Residence of Decedent								111 1975				
i		10a. State 10b. County		10c. City, To	own or Loc	ation							1	0d. Inside City Limits
	Director	MARYLAND CHARLI	ES	POMF	RET									1 X Yes 2 □ No
	Die	10e. Street and Number 7900 MARSHALL CO	RNER ROAD			10f. Zip	^{Code} 2067	5					Vhat Cour STAT	
	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. W	as Decede	nt of His	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.))-			can Indian,
	∄	1 Never Married 2 Married	Armed Forces?	0		_			i, Puerto i	tican, etc.)		Blac	k, White,	etc.
	<u>م</u>	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2	∆] No	Specify:				Specify	BLA	CK
	Completed	15. Decedent's (Specify only highest g		16	Sa. Decede	ent's Usual	Occupa	tion uring most	t of workir	na	16b. l	Kind of Bu	usiness/In	dustry
	g	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. D	O NOT use	retired)			3	-		0011	TO MENT
	ပွဲ	12TH GRADE			SEC	RETAR	Y							ERNMENT
	Be	17. Father's Name (First, Middle, Las	st)							(First, Middle			10)	
	ဥ	JOSEPH CARTER								COOPER				
		19a. tnformant's Name/Relationship ALBERT E. SWANN			_					ARYLAN		or Town, 20675		Code)
		20a. Method of Disposition		20b. Place	of Dispos	ition (Nam	e of	1	D	ate	20c. L	ocation -	City or To	own, State
.		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		ST. JO					UCUST	28,2006	POM	FRET	. MAI	RYLAND
ä	-	21. Signature of Furreral/Service Life	enseet ale		22.	Name and	Addres	s of Facilit	ν					
Suc		LYDIA C. THORNION	JOHNSON MO	0583	343	ORNION 19 LIVI	PUNE NGST	KAL HU IN ROA	ME, P D. IN	A. DIAN HEA	D. M	RYLAN	D 20	640
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused to one cause on each lin	the death. D										Approximate Interval Between
an		Immediate Cause (Final disease or condition	ACUTE PU											Onset and Death
al		resulting in death)	Due to (or as a											
er		Conventially list conditions	, OBSTRUCT	IVE PU	ILMONA	ARY L	ESIO	N						
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a											
	Examiner	Cause (Diseese or injury that initiated events resulting in death) Last	_{c.} PEREPHER			DIS	EASE							
	Ě	resulting in death) cast	Due to (or as a											
	Medical		d. ARTERIOS	CITEROS	010									
	Me	IF FEMALE;	23c. If yes, outcome of	4										
		23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 💹 No	1 Live birth	2 ☐ Fetal dea	ath 3 🗆 E	Ectopic pre						23d. Dat Mo	te of delive nth	Day Year
	ysic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4∐Pregnant al : 9☐ Unknown	time or death	20	Other (spe	спу)							
	by Physician	Part II. Other significent conditions	contributing to death bu	t not resulting	g in the und	derlying ca	use give	n in Part I.		23e. Did t	obacco	use cont	ribute lo th	ne cause of death?
	9	DIABETES MELLITU	S, CEREBROV	ASCULA	R ACC	CIDEN	Т,			1 🗔	Yes 2	2 □ No	3 ☐ Prob	pably 4 Unknown
	ete	CORONARY ARTERY	DISEASE CA	ROTTD	ARTEI	PY ST	ENOS	TS		24a. Was			Nore auto	ney findings available
	Completed									auto		1	prior to condeath?	psy findings available mpletion of cause of
		OBESITY, SARCOID 25. Was case referred to medical	USIS, HIPER	TENSIC	JN, H	YPERC.	HOLL			A 1 ☐ Yes (Check only o		0 1	I ☐ Yes	2 No
	To Be	examiner? 1 ☐ Yes 2 X No	Hospital:	2 X FB/	Outpatient	3 🗆 DO	Othe	-		ne 5 Resi		6 □Oth	or (Specifi	ivl
		27. Manner of Death	28a. Date of Injur (Month, Day	v 28t	o. Time of		c. Injury Work			8d. Describe				"
	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigati		7647)	Injury	М		es 2 🗆 1	No					
	100	3 ☐ Suicide 6 ☐ Could not determine	be 28e. Place of Inju	ry - At home,	, farm, stre	et, factory,	office		2	8f. Location (Street a	nd Numb	er or Rura	il Route Number,
	Cert	- Carronness	building, etc	. (Specify)						Only of 10	wii, Olai	0)		
	Medical Certification:	29a. Certifier (Check only one) Cartifying F	Physicien: To the best of eminer: On the basis of and manner sta	examination	dge, death and/or inve	occurred a stigation,	it the tim in my op	e, date and inion, deat	d place, a th occurre	nd due to the ed at the time,	cause(s	s) and ma nd place, a	and due to	tated. o the cause(s)
	ž	29b. Signature and title of certifier	1		. 40	29c.	License	number			29d. D	ate signe	d (Month,	Dey, Year)
		Druga Ch	title	Sept	WD .]	D-00	08370)		AUGU	JST 2	23, 2	006
		30. Name and address of person whe PRITCHETT, PAUL					c /	D O	DOV	1017 7		400	350-	
Stat		31. Date filed (Month, Day, Year)	32. Pojistra	r's Signature				r.U.	DUX	131/ F	A PI	AIA,	MAR	YLAND 20646
istra		AUG 2 4	2006	w b	de	rende								
	01		,		-7									

Registrar

			For State Registrar	State of Maryla		artment of H		Mental Hygi	ene 2006	28381
	Physicia	an	1. Decedent's Name (First, Middle, La Rebecca Lake	Sliger				2. Date of Death Month 8/27/06	Day Year	3. Time of Death 4:55 p M
	/Medid Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	Location of Death		4c. County of Dea	
	Examin	eı	107 Sunny Side R			Oakla			Ga	rrett
	Funeral Director		5. Social Security Number 6. S		rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 2/12/19	9. Bin (C) 13 M	thplace (State or Foreign ountry) aryland
	Pu ≱		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	ecation				10d. Inside City Limits
	Aaryie r sho	ō		rett	Oak1a					1 ☐ Yes 2 No
	the 28a-	rect	10e. Street and Number	1000	Oakla	10f. Zip Code		10	g. Citizen of What C	ountry?
	h with	aj D	107 Sunny Side R	d.		2155	0		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Evarteric triust by ruffled an once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🗓 No	ın, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi Specify:	
ò	2 hou		15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation	1	6b. Kind of Business	
215	thin 7 e. en "n	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	1)	rking		
2	ygien ygien ner th		4th			Home Mak		(F) . A411# . A4	Hom	e
Maryland 21215-0036	ould be fil Mental H arked oth atic even	To Be	17. Father's Name (First, Middle, Last Presley	P a ugh			18. Mother's Nam	ne (First, Middle, M a Cat	herine	Paugh
Jar	2 sho	0.00	19a. Informant's Name/Relationship						City or Town, State,	Zip Code)
Baltimore, I	ges 1 and t of Healtl If item 27 or other t		Phyllis Barnard/ 20a. Method of Disposition 1 X Burial 2 Cremation 3 [201	o. Place of Dispo	was not a first own		Swanton,	MD 21561 Oc. Location - City of	Town, State
ţ Ţ	t. Pag tment tent; ijury		' 4 ☐ Donation 5 ☐ Other (Speci	(y) G		Co. Mem.		A CONTRACTOR OF THE PARTY OF TH		Maryland
Bal	Depar Depar Impor any ir	10	21. Signature of Funeral Service Fice	n see		Name and Address Sec			uneral Ho MD 21550	me
	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	pplications that caused the done cause on each line. a. Cerebralv			g, such as cardiad	or respiratory arres	st,	Approximate Interval Between Onset and Death YTS
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	sequence of):				,	
,0928	cate be executed physician and the burial-transit	dicai Exa	resulting in death) Last	Due to (or as a cons	sequence of):					
687	tificate ng phys as the	edic		d						
O. Box	death cer e attendir ed for use	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other <i>(specify)</i>			23d. Date of de Month	livery Day Year
ds, P.	S C 0	d by Ph	Part II. Other significant conditions Atrial Fibrill		resulting in the u	nderlying cause giv	en in Part I.			o the cause of death?
Vital Record	aw Is t	Completed	Diabetes Melli	tus II				24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
a	n: The licate har, page							1 ☐ Yes 2	X No 1 □ Ye	s 2□ No
ξ	Physicien: rthis certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2	□ EP/Outpotion	nt 3□ DOA Oth	Committee of the Commit	ith (Check only one		
on of	ding Phy h. After this funeral d	tion: To	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year		f 28c. Injur		28d. Describe hov	ice 6 Other (Spe vinjury occurred	ecity)
Division of	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification	2 Accident investigation 3 Suicide 6 Could not to determined	De Place of Injury - A	t home, farm, str ecify)			28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	e Hospitel 24 hours a e Funerel l	edicai C	29a. Certifier (Check only one) 1X Certifying P 2 Medical Exa	hysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Mon	th, Day, Year)
	6		Duni	ulu de	2_	Н	26154		8/29/06	
	· ·		30. Name and address of person who Paul D. Miller			·	s, Oakla	nd, MD 21.		
:1	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Si		gentle)				

			1 - State of M	laryland / Dep <i>Ce</i>	ertificate of E	ealth and M Death		iene _{eg. No.} 2006	28382
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Deat Month	th Day Year	3. Time of Death
	/Media		Betty Jean Simmons				August	18 2006	11 15 AM
	Examir	er	4a. Facility Name (If not institution, give street and number	> -	4b. City, Town, or	Location of Death		4c. County of Death	1)
			LORIEN (W KIVERSI.	DE	DE	ICAMO		MAKTOR	0
	Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday 58 Yrs.	Months Days	If Under 24 Ars. Hours Min.	8. Date of Birth (Month, Day,	Year) Cour	
Ш.	Director		Usual Residence of Decedent	30			March 3	, 1948 Nev	w York
	yland 10w		10a. State 10b. County	10c. City, Town or L	ocation			1	10d. Inside City Limits
	Mar st	tor	Maryland Harford		Havre de	e Grace			1 May Yes 2 □ No
	or 28	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What Cour	ntry?
	th wil	a	527 Battery Drive			21078		USA	
	ems ems	Funeral	11. Marital Status 12. Was Deceden	Ever in U.S. 13.	. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spo	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	an Indian,
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show its Modeal Extratinatia and be modified at	y Fu	1 Never Married 2 Married 1 Yes 2 If Yes, Give	₹ Vo	1 Yes 2 XNo	Specify:		Specify: Bla	
8	ural',	d by	3 Wildowed 4 Ulivorced Year or Dates:						
21215-0036	n 72	Completed	15. Decedent's Education (Specify only highest grade completed)	(Giv	edent's Usual Occupa re kind of work done do DO NOT use retired)	uring most of work	ing	16b. Kind of Business/In	dustry
12	withi ene. than	mc	Elementary/Secondary (0-12) College (1-4or	5+)	Crossing			City Police	e Department
	filed Hygid other ent, II		17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, M		s Department
an	ould be Mental arked c	To Be	Alfred L. Carter			Vernel l	L. Thou	NOT	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, I're M.	 -	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ling Address (Street a			, City or Town, State, Zip	Code)
-	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-1 show other traumatic event, Ire Medical Exir. If yether traumatic event, Ire Medical Exir. Ire Ire Ire Ire Ire Ire Ire Ire Ire Ire		Charles Simmons / husband	42	27 Battery	Drive H	lavre de	Grace, Mary	dand 21078
Baltimore,	es 1 a of Hez of Hez fitem r othe		20a. Method of Disposition	20b. Place of Disp	position (Name of ematory or other place	' I	Date	20c. Location - City or To	own, State
Ë	Pag ent ent rt: I		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)		Memorial (' 1	25/06	Aberdeen.	Maryland
a E	artmartmorta		21. Signature of Funeral Service Licensee		22. Name and Address	s of Facility			· Lary Lario
m	Depar Impo		Scott-Gold	man	Lisa S	Scott Fun	eral Hon	ne, P.A. ce de Grace,	м _D 21078
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause of each	d the death. Do not en	nter the mode of dying	, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	1100 G	ailun	2			Onset and Death
7	/Medical		resulting in death)	s a consequence of):	+ 1			,	
	Examiner		Sequentially list conditions.	Posilero	lic and	DUTULL	lar	disease	2
	p ji	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):		1 -	8 8	7 SS S S	
	and I-tran	хаш	that initiated events	s a consequence of);	Yansp	Gen!			
8760,	be executed sician and burial-transit		DA		MARIE	1			
687	ate the	dical	d	THE COO	receve				
ox (leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcom	e of pregnancy				23d. Date of delive	any
B	death atter	ciar	in the past 12 months?		☐Ectopic pregnancy ☐ Other (specify)			Month	Day Year
o.	t the d by the tached	hysi	9 Unknown						
s, P	es that igned to be deta	by Pi	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause give	n in Part I.	23e. Did tob	pacco use contribute to th	ne cause of death?
rds	v require been sig should b	pa					1 🗆 Ye	s 2 No 3 Prob	ably 4 Dunknown
Record	The law requires that the site has been signed by the bage 2 should be detache	Completed					24a. Was a	n 24b. Were auto	psy findings available impletion of cause of
Ä	The lavate has page 2.	E O					autops perform 1 ☐ Yes 2	ned? death?	
Vital	ician: Th certificate rector, pag	Be C	25. Was case referred medical			26. Place of Death			
of V	dii d	10	examiner? 1 Yes 2 No Hospital: 1 Inpat	ent 2 ER/Outpatie	ent 3 DOA Other	r: 4 Nursing Ho	me 5 Reside	nce 6 Other (Specify	1)
			27. Manner of Death 28a. Date of inj 1	ury 28b. Time (of 28c. Injury Work	at ?	28d. Describe ho	w injury occurred	
sio	Attending ir death. ector: After by the fune	catl	2 Accident investigation			es 2 No			
Division	Il or Attend after death Director: ,	Certification:	4 Homicide determined 28e. Place of Ir building, e	ijury - At home, farm, si tc. <i>(Specify)</i>	treet, factory, office		28f. Location (Sti City or Town	reet and Number or Rura ı, State)	l Route Number,
	pital urs a sral C		Constitute Dhysician Tallaham						
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the besis one) 2 Medical Examiner: On the basis and manner s	of examination and/or i	nvestigation, in my opi	e, date and place, inion, death occurr	and due to the ca ed at the time, da	tuse(s) and manner as st ate and place, and due to	ated. the cause(s)
	ithin o the comple	Med	29b. Signature and title of certifier	iatos.	29c. License	number	1 29	9d. Date signed (Mogsh,	Day, Year)
	F 3 F 8			1110	Da	offi	/ _	Via.	7-6
,			30. Name and address/oligerson who completed cause of	eath (Item 23a) (Type	p. Print)	1	2	YUTC	
	-0^		TTLOG MD 66	Pour O.	tion st	Keur	p de	race MI	72/078
4.4	Sta	ite	31. Date filed (Month, Pay, Year) 3 2006 32. Regist	rar's Signature	hall s	V V		, cop	10
	Registr	ar	NOG & 0 2000	EUR ST 1	The same of the sa				

Betty J. Simmons

State of Maryland / Department of Health and Mental Hygiens 2 2 2

		Certificate of Death	Reg. No. 006 28383
	1. Decedent's Name (First, Middle, Last)		Dete of Deeth 3. Time of Death
Physiciar /Medica	IONN BIWOOD Schlocenacia		Aug. 23 2006 9:00 PM
Examine	An Franklin Name (Manh institution of the state of the st	4b. City, Town, or Loc	cation of Death 4c. County of Death
	Oakland Nursing & Rehabilitation		Garrett
Funeral Director	5. Social Security Number 215-26-9527 Usuel Residence of Decedent	Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) July 7, 1925 9. Birthplece (State or Foreign Country) Maryland
a Mand		wn or Location	10d. Inside City Limits
Mary Hary	MD Garrett Oa	kland	1 □ Yes 21√2 No
the root	10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
ath with the Marylan 23a or 28a-f show wat be notified at	MD Garrett Oa 10e. Street end Number 109 Oak Hall Drive 11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married	21550	United States
deal	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Cuban, Mexican, Puerto F	cify Yes or No- 14. Race - American Indien,
.0036 hours after death with the Maryland tursi', or items 23s or 28s-f show at Examiner must be notified at		1 ☐ Yes 2 🗓 No Specify:	
DOO Jours	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	TE 103 ZULTO Specify.	Specify: White
Ind 21215-003 be filed within 72 hours a ital Hygiene. d other than "natural", c event, the Medical Exam-	15. Decedent's Education (Specify only highest grade completed)	 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 	16b. Kind of Business/Industry
within 72 ene.	Elementery/Secondary (0-12) College (1-4or 5+)		
d 212: filed within Hygiene. rither than ent, tre M	12 17. Father's Neme (First, Middle, Lest)	Route Salesman	Wise Potatoe Chips (First, Middle, Maiden Sumame)
aryland should be fill and Mental H marked out		Nellie	
Marylan 2 should be 2 should be and Mental is marked raumatic ev	Elwood Schlossnagle 19a. Informant's Name/Relationship (Type, Print) 19	b. Mailing Address (Street and Number or Rurel	Spoerlein Route Number City or Town, State Zin Code)
Malth ar allth ar trau		27 Cherry Lane, McHeni	
NOTE, Maryle	20a. Method of Disposition 20b. Place	of Disposition (Name of	Date 20c. Location - City or Town, State
Do Pages ent of	Manual 2 Cremation 3 Chemoval from State	ery, crematory or other place)	/27/06 October MD
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. Important: if fem 27 is marked other than "natural; or any injury or other traumatic event, tra-Medical Examples.	21. Signature of Funeral Service Licensee	22 Name and Address of Facility	/27/06 Oakland, MD
Depa Impo	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	The state of the s	rdock-Durst Funeral Home Second St., Oakland, MD
The second	23a. Perl1. Enter the disease or complications the dused the death. Do shock, or heart failure. List only one cause sech line.		
Physician	shock, or heart failure. List only one cause ***ech line.		Interval Between Onset and Death
/Medical	Immediate Ceuse (Final disease or condition	leratic cordiovosc	ular disease 2 weeks
Examiner	Due to (or as a	consequence of):	167 5.30,5
pe sit	- h		
Records, P.O. Box 68760, The law requires that the death certificate be executed at a has been signed by the ettending physicien end page 2 should be detached for use as the buriel-trensit completed by Physician Medical Examiner.	Sequentially list conditions, Due to (or as e	consequence of):	
68760, ificete be ex g physicien es the buriel	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events.		
680 Hicete	resulting in death) Lest	consequence of):	
OX O	d		
death or e ettend ad for us	Part fl. Other significent conditions contributing to deeth but not resulting	in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?
P.O. hat the de by the detached	asachanal carren		1 Yes 2 No 3 Probably 4 Unknown
S, las this as this igned be de	esophogeol cancer		
Division of Vital Records, P.O. Box or Attending Physician: The law requires that the death cert after death. Director: After this certificate has been signed by the ettendin in by the funeral director, page 2 should be detached for use extification: To Be Completed by Physician/A	diobetos mellitus	type two	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause
law law law law law law law law law law		18	of death?
Cata t			1 Yes 2 ONO 1 Yes 2 No
Vita iclan: certifii ractor	25. Was case referred to medical examiner?	26. Place of Death	
Physic This carried in a light of the light	1 Inpatient 2 ER/O	utpatient 3 DOA 412 Nursing Hom	e 5 Pesidence 6 Other (Specify) 3d. Describe how injury occurred
on olling the After fune	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Time of 28c. Injury at 28 Work? M 1 Yes 2 No	
Atten r daar r daar r daar sector: by the	3 Suicide 6 Could not be determined 28e. Place of Injury At home, for	arm, street, factory, office 28	Bf. Location (Street end Number or Rural Route Number,
Division c bis or Attending Pl tai or Attending Pl tai or Attent al Director: After th led in by the funera Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, Stete)
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Certifier 15 Certifying Physician: To the best of my knowledg (Check only 2 Medical Examiner: On the basis of exemination er		
thin 24 thin 24 thin 24 thin 5			
S S S S S S S S S S S S S S S S S S S	29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Il for Mane	0002373	9 August 24. 2006
5	30. Name end eddress of person who completed cause of deeth (Item 23e)	PO Box 247 Acci	10 + M 1 21520
State	31. Dete filed (Month, Dey, Year) 32. Registrer's Signature	71, 1001	VIEW IN TILL
Registrar	AUG 2 5 2006 ▶	to A of	
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Manyland / Department of Health and Mental Hygiene

Patricia Thompson		Sta	te of Marylan		rtment of tificate of			al Hygi		2	006	2838
Physician		Registrar 1. Decedent's Name (First, Middle	,Last)		-	Dodan	·		Date of Death	ı. No.		me of Death
Medical Examine	er	Patricia 4a. Facility Name (if not institution	Lynn give street and numb		omp5		wn, or Location o	Α	Month ugust 20,	Day Year 2006 4c. County of		135 hrs
		Wahington County Hos	. 0	01)		Hagers		r Bedan		Washingt		
Funeral Director				Age (In yrs. la		If Under Months		1.00		(MM/DD/YYYY)	 Birthplace Foreign Country) 	- 1
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nnd show any ace.		10a State 10b. County Md. Frede	erick		Town or Locat							Inside City Limits Yes 2 No
4D 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f show matter event, the Medical Examiner must be notified at once.		10e. Street and Number 217 Knox	ville Re	oud		10f. Zip C	ode 21758	,	100	g. Citizen of Wha		
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urs after tural", c	하	3 Widowed 4 Divo	rced If Yes, Give Year or Dates: fy only highest grade of	completed)	1 16a. Deceder	Yes 2	No specify:	ind of work	done	Specify L	U /-// /	
)36 thin 72 hour than "nat edical Exa	Completed	Elementary/Secondary (0-12)	College (1-4			ost of worki	ng life. DO N OT i			RESTA		•
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after no of Health and Mental Hygiene II: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner.	Be Con	17. Father's Name (First, Middle, L LESTER J.		~					rst, Middle, Ma	aiden Surname)		
MD 21 d 2 should lith and Mer n 27 is man umatic ev	P	19a. Informant's Name/Relationsh Clarence £.		(hueb)	19b. Mailing	Address	(Street and Num avket	ber or Rura	hede	rick, n	nd. 2	1701
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other injury or other traumatic event, the Mental Injury or other traumatic event,		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Spe	3 Removal from	State	Place of Dispos rematory or ot	ition (Name ner place)	of cemetery,	Da	ate	20c. Location - (City or Town,	State
Baltimo permit. Pag Department Important: injury or of	İ	21 Signature of Funeral Service L		1/ 4/	22. N	lame and A	ddress of Facility West	as FU	NEVAI B St	weden	d Mi	21701
Physician /Medical		23a. Part I. Enter the disease, or of failure. List only one cause of	on each line.								t App	oroximate Interval ween Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co		·):							
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ox 687 ath certifications attending	sician/l	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unkr	4 Pregnant	at time of de	2 Fe	tal death her (Specif		pregnancy		23d. Date of d Month	elivery Day	Year
ords, P.O. B wrequires that the d s been signed by the should be detached i	by Phy	Part II. Other significant condition			esulting in the u	ınderlying c	ause given in Par	rt 1		acco use contrib		
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Vital vsician: his certifi director,	Be [25. Was case referred to medical examiner?	Hospital:				Place of Death (
n of Vir ling Physi After this funeral dir	읽	1 Yes 2 No 27. Manner of Death	28a Date of	atient 2	ER/Outpatient 28b. Time of I		c. Injury at Work		d. Describe ho	esidence 6		e
Division tall or Attendin is after death all Director: A led in by the fur	ertification		Igation Aug 20, 20	06		B:36 pm et. factory. c	1 Yes 2	No	ver auto co	ollision eet and Number	or Rural Ro	ite Number City
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E 3 E 3	Me	29b. Signature and title of certifier					O.C.M.E.			29d. Date signed August 21, 2		iy, Year)
		30. Name and address of person v Ana Rubio MD. Assi		•	,	Stroot Pa	altimore MD	21201	I			
Sta	ite	31. Date filed (Month, Day Year)	stant Medical Ex		re & A		altimore, MD :	<u> </u>				
Registr	ar	AUU &	0									

State of Maryland / Department of Health and Mental Hygiene 2005 28386 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** August 13, 2006 3:22 рм Joseph Tumminello /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 849 Pat Lane Arnold If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 8. Date of Birth
(Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 96 Yrs. Director 215-07-4868 27, 1909 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Anne Arundel Arnold 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 or itema 23e 849 Pat Lane 21012 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant If item 27 ie marked other then "naturel", or itema 23. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Produce Supervisor Food Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Vincenzo Tumminello Mary Cascio 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anelle Tumminello/Daughter 849 Pat Lane Arnold, MD 21012 other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug. 16. 20c. Location - City or Town, State ö permit. Page Department of Importent: If any injury or once. Metro Crematory Baltimore, MD 4 Donation 5 Other (Specify) 2006 21. Signature of Fane al Service Licensee Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 Thin. Enter the classes, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** onges 17 1001 ears /Medical Due to (o) as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 attending physician Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Onknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform rs after deam.
rai Director: After this ceru...
in by the funeral director, pe 2 No 1 Yes 2 No 1 🔲 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 15 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Matural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ţ 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) teransthwy M. Wersv. lle, 30. Name and address of person who completed cause of death (Item 23a) (Type. enniter 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar			tate o	f Maryl	land / [epa <i>Cer</i>	rtmen tificat	t of H	ealth a	and M	ental Hy	Reg. No.	111	06	28387
•	Physicia /Medic Examine	in al	1. Decedent's Name (f JANE FO 4a. Facility Name (If no Genesis	OSTER '	TUCKI	et and nur	nber) - The	Pin	es	4b. City,		Location of	of Death	2. Date of D Month Aug	Day 1 9	2 (ounty o	Year 006 of Death Lbot	3. Time of Death 6 • 45 AM
	Funeral Director		5. Social Security Num 219-01-270		6. Sex 1 ☐ M	XX ⊧	7. Age (In)	yrs. last birt	hday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	irth 8, Ye <i>ar)</i> 8, 191	8	9. Birthpl Count MARY	ace (State or Foreign ry) LAND
	Maryland e-f show life f at	tor	Usual Residence of De 10a. State 10	0b. County	TALBO	OT	100	. City, Town	or Loc								10	0d. Inside City Limits 1 Yes 2 □ No
	with the	Direc	10e. Street and Number 512 EAST		T)					10f. Zip		654			10g. Citize	n of WI	hat Count	ry?
0036	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show iteal Examinar must be notified at	d by Funeral Director	11. Marital Status 1 □ Never Married 3 ▼Widowed 4 [2 Marrie	12. y	Armed Fo 1 ☐ Yes If Yes, Giv Year or D	2 X No /e	in U.S.		Vas Decec Yes, spec	lent of His cify Cubar	spanic Ori n, Mexicar	gin? (Spe n, Puerto l	cify Yes or N Rican, etc.)	o- 14	Race Black pecify:	- America , White, e	TE
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ane , Mar	d 2 sho th and th ema treume		19a. Informant's Name			-)	12						Route Numb				Code)
J a Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "neturel", or Items 23e or 28e-1 show any injury or other treumetic event, the Medical Examinat must be notified at once.		20a. Method of Dispos 1 X Burial 2 0 4 0 Donation 5 1 21. Signature of Funer	ition Cremation : Other (Spe	3 □Remo ecify) icensee	oval from	State 20	b. Place of	Dispos y, crem CE	sition (Name and Name	ne of ther place RY d Addres	s of Facilit	8/25	/2006	20c. Loca)RD,	Dity or Tov	YLAND OME PA
8760,	ate be hysicia the bu	dical Examiner	shock, or heart for the state of the state o	tions, ediate ng ury	a b c d	Due to	or as a con	asequence of		frbr	0515							Interval Between Onset and Death
Box 6	ithat the death certificated by the attending pion of detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pr in the past 12 mc 1 ☐ Yes 2 N 9 ☐ Unknown	inths?		1 Live b	ant at time	Fetal death		Ectopic pr Other (sp					23	d. Date Mont	of deliver	y Day Year
Records, P.O	law requires that some as been signe 2 should be c	Completed by Ph	Part II. Other significa	int condition	ns contrib	nuting to de	eath but not	t resulting in	the un	derlying c	ause give	n in Part I		24a. Was	Yes 2 s an ppsy comed?	No 3 24b. We pri	ere autopior to comeath?	sy findings available pletion of cause of
/ital	rsicien: The faw s certilicate has t lirector, page 2 s	Be	25. Was case referred examiner?	to medical							Lou			1 ☐ Yes (Check only			Yes 2	
Division of Vital Records,	Attending Phy in death. ector: After this by the funeral c	Certification: To	2 Accident	5 Pending investiga 6 Could no determin	ation ot be	28a. Date (Mont	of Injury th, Day Yea	At home, fai	ime of njury	M 2	8c. Injury Work 1 🗆 Y	4,100	No 2	ne 5 ☐ Res 8d. Describe	how injury o	occurre	d	Route Number,
Di	a Hospitel or 24 hours afte Funerel Dir etely filled in		29a. Certifier	Certifying	Physicia	an: To the	best of my	knowledge	, death	occurred	at the time	e, date an	d place, a	nd due to the	cause(s) ar	nd man	ner as sta	ited.
	To the H within 24 To the Fi	Medical	29b. Signature and title	e of certifier	M	and mani	ner stated.	Tho		290	License		95)	3	29d. Date	signed		Pay, Year)
_	10 -	te	MICHAEL 3	D. CRO	WLEY	, M.I		3 IDLE			E. E.	ASTON	, MD	21601				

06-06166 Please Type or Print in Black Indelible Ink James Thomas State of Maryland / Department of Health and Mental Hygiene 2006 28388 1- For State Certificate of Death Reg No Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day August 18, 2006 0923 hrs Medical Examiner Thomas James Henry 4a Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Salisbury Wicomico 5. Social Security Number . Age (In yrs. last birthday If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 222-34-9681 Oct.2,1952 Country)De. 1 XM 2 Yrs 53 Usual Residence of Decedent ì 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits or items 23a or 28a-f show must be notified at once. 1 X Yes 2 No permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. De Sussex Millsboro Director 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country 19<u>966</u> 31438 Karan st Funeral 2. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married XYes Yes, Give Year 1 Yes 2 X No specify Black 3 Widowed 4 Divorced Specify 1972 ģ Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Truck Driver Parker Block Co. 11th 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be James Edward Th

19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Emmer S. Thomas/Wife 31438 Karan st. Millsboro, De. 19966 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State St.John Church Cem 8/23/06 Millsboro, De. Donation 5 Other Specify 22. Name and Address of Facility Bennie Smith Funeral Home n n re of Euneral Service Licensee st. Salisbury, Md. 21801 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line /Medical Death a Complications of multiple injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate ner Due to (or as a consequence of) cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical attending physician or use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown a Unknown the Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. è Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of After this certificate has performed' death? 1 🗸 Yes ✓ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medica 26 Place of Death (Check only one) Be examiner? Other₄ ✓ Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 🗸 Yes 28a. Date of Injury (Month, Day Year) Aug 14, 2006 28b. Time of Injury 27. Manner of Death 28d Describe how injury occurred 28c. Injury at Work' Pedestrian struck by auto 1030 hrs Natural Yes 2 V No 5 Pending in by the 2 🗸 Accident 28e Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Route 113, Millsboro, DE (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started To the l 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. h August 19, 2006 mo 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

31. Date filed to the

2 4 4 e a 2 0 0 S

32 Registrar's Signature

Anne Receiver Tee! Anne Arundel Medical Center Funded Director Funded D	28389	giene Reg. No. 2006	Mental Hygi			artmen rtificate		of Marylar	State		1 - For State Registrar			
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To Father's Name (First, Middles, Macden Sumania) To Pather's Name (First, Middles, Macden Sumania) To Pat		-	10	19973		10f. Zip			Road			al Dire	23a or 28	th with the
To Further's Name (First Middle), Macden Surnamin) To Further's Name (First Middle), Macden Surnamin, Surna		Black, White	Specify Yes or No- to Rican, etc.)					orces? 2 📉 No ve	Armed Fo		1 Never Married	by Funer	al', or items	036 urs after dea
23. Part Letter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and shock, or heart failure. List only one cause on each ine. Colon Cancer 2	·		rking	on ing most of work	rk done di se retired)	kind of woi DO NOT us	(Give	1-4or 5+)	rade completed)	ify only highest g	(Specify Elementary/Second	ompleted	iene. than "natur I'e Medical	1215-0 within 72 ho
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Stock, or heart failure. List only one cause on each line. Colon Cancer		, Annapolis	ster St.,	Glouces	ce of	7 Dul	14 ب	We	2- X	rdel E) dor		ode Eny	
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The state of the s	1 week						uence ot):		Pn					
Temporary Temp							uence of):	(or as a consec		rhying Injury	cause. Enter Underly Cause (Disease or in	nlner	nsit	pet
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The complete of the complete	very Day Year						I death 3	ointh 2 ☐ Feta nant at time of o	1⊡Live I 4⊡Pregi		23b. Was decedent p in the past 12 m 1 Tes 2	ysician/Med	nding p	. Box 68
25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Mayner of Death 28. Injury at work? 28. Injury at work? 28. Injury at work? 28. Injury at work? 28. Injury at work? 28. Injury at work? 28. Injury at work? 28. Injury at work? 28. Injury at work? 28. Injury at work? 28. Injury at work? 28. Injury at work? 28. Injury at work? 28. Injury at work? 28. Injury at work? 28. Injury at work? 28. Injury at home, farm, street, factory, office 28. Location (Street and Number or Rural Rocking of Parking Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the officer of parking Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the officer of parking Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day August 18, and manner stated) 29b. Signature and the object of parking Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day August 18, and manner stated) 29c. License number 29				in Part I.	ause give	nderlying c	ulting in the u	eath but not res	contributing to d	icant conditions	Part II. Other signific		an signed b	rds, P
The state of the s	opsy findings available ompletion of cause of	prior to c rmed2 death?	autopsy perform									Complet	ate has page 2	
The state of the s					Otho				Hospital:	•	examiner?	Be	certific rector,	Vita lician
29a. Certifier (Check only one) 29a. Signature and the lime, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the of certifier (Sheck only one) 29b. Signature and the of certifier (Post only one) 29c. License number (Post only one) 29d. Date signed (Month, Day D64089 August 18, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Sanchez, MD 2001 Medical Parkway Annapolis, Maryland 21401	<u>fy)</u>				8c. Injury Work	2	28b. Time o	of Injury	28a. Date (Mon	h 5 □ Pending	27. Manner of Death		After th	¿ o
29a. Certifier (Check only one) 29a. Signature and the lime, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the of certifier (Sheck only one) 29b. Signature and the of certifier (Post only one) 29c. License number (Post only one) 29d. Date signed (Month, Day D64089 August 18, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Sanchez, MD 2001 Medical Parkway Annapolis, Maryland 21401	al Route Number,	Street and Number or Ru m, State)	28f. Location (Stre City or Town,		, office	eet, factory	ome, farm, str y)	of Injury - At hing, etc. (Special	1 289. Place			Certific	s efter de al Directo ad in by th	Divis
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			Marriand	molic '	Ληη			-	•	,			2.	1 '
State Registrar 31. Date filed (Month, Day, Year) 2006 Registrar's Signature		J 214UI	riat ytalia	imits' i	WITT.	May								

	State Registrar			Cer	tificate of Death		Reg. No.	2006	2839		
0.0	1. Decedent's Name (First, Middle,	Last)				2. Date of Dea	Day	Year	3. Time of Death		
ian cal -	Wanda Tebinka					August	18,	2006	5:23 A M		
ner '	4a. Facility Name (If not institution,	-	mber)		4b. City, Town, or Location of De	ath		County of Death			
	2701 Martello I 5. Social Security Number	Orive 6. Sex	7. Age (In yrs. last	hirthday	Silver Spring If Under 1 Year If Under 24 H	rs. 8. Date of Birt	h	ntgomer	y place (State or Foreign		
	109-16-1823	1□M 2₹ F	95		Months Days Hours Mi	n. (Month, Da)	1911	Cour	ntrv)		
-	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation			1	0d. Inside City Limits		
Direction of	Maryland Montgo	mery	Silve	r Spr	ing				1 ☐ Yes 2 🛣No		
. .	10e. Street and Number 2701 Martello Dr	ive			10f. Zip Code 20904		10g. Citiz USA	en ol What Cour	ntry?		
L	11. Marital Status		edent Ever in U.S.	13 \	Vas Decedent of Hispanic Origin?			4. Race - Americ	can Indian		
	1 Never Married 2 Marrie	Armed Fo	orces? 2 ⊈No	"	Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)		Black, White,			
•	3 ☐ Widowed 4 ☑ Divorced	If Yes, Gi Year or D	ve 41	1	☐ Yes 2 X No Specity:			Specify: Wh i i	te		
	15. Decedent' (Specify only highest		1	(Give	lent's Usual Occupation kind of work done during most of w	vorking	16b. Kin	d of Business/In	dustry		
	Elementary/Secondary (0-12)	College (OO NOT use retired)						
)	17. Father's Name (First, Middle, L	ast)	R	egist	ered Nurse	ame (First, Middle,	Healthcare Maiden Sumame)				
Peter Paul Ceglarek Mary M. Kolanek								, , , , , , , , , , , , , , , , , , , ,			
•	19a. Informant's Name/Relationsh	r, City or	Town, State, Zip	Code)							
	MD 2086	56									
	20a. Method of Disposition 1										
	4 □ Donation 5 □ Other (Sp			apeak	ce Crematory 08	/22/06	Belt:	sville,	MD		
	21. Signature of Funeral Service L	icensee H	malas	GC Be	Name and Address of Facility Sing Home Cremat Everyl L. Heckro	ion Servi	ce :	P.O. Box	x 784		
+	23a. Part1. Enter the disease, or	complications that of	caused the death. [IKSVIII	Approximate		
	shock, or heart lailure. List of Immediate Cause (Final			1					Interval Between Onset and Death 2 1/2 vear		
	disease or condition resulting in death)	a	iple Stro						z 1/z year		
	Sequentially list conditions,	b Gene	ralized A	ther	osclerosis	\cap		- 2	30 years		
	if any, leading to immediate cause. Enter Undertying	Due to	(or as a consequen	ce of):	/	12					
	Cause (Disease or injury that initiated events resulting in death) Last	C	(1/1	1				
	rosaling in dodain Edst	Due to	(or as a consequen		101622	1 00					
	67	d			M	ENI					
	IF FEMALE:	23c. If ves. ou	tcome of pregnancy	/	,		25	3d. Date of delive	201		
3	23b. Was decedent pregnant in the past 12 months?	1☐Live t	ointh 2 ☐ Fetal de nant at time ol death	ath 3	Ectopic pregnancy Other (specify)		2	Month Month	Day Year		
	1 ☐ Yes 2 X No 9 ☐ Unknown	9□ Unkn	own								
-	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to								ne cause of death?		
	Part II. Other significant condition		acture			1 🗆 Y	es 2 🛚	No 3□Prob	ably 4 Unknown		
	Part II. Other significant condition Status/post Rigl	nt hip fr									
הברי לברי בלים בלים בלים בלים בלים בלים בלים בלי				nagia		24a. Was		24b. Were auto	psy findings available		
Ollipiered by	Status/post Rigl			nagia		autop perfo	sy med?	24b. Were auto prior to co death? 1 \(\subseteq \text{Yes} \)	mpletion of cause of		
(Status/post Right esophygeal dysfu	unction w		nagia		autop perfo	sy med? 2 No	prior to co death?	mpletion of cause of		
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(b)02

George F. Sengstack, M.D. 3929 Ferrara Drive Wheaton, MD 20906 31. Date filed (Month, Day, Year)
AUG 2 4 2006

32. Segistrar's Signature

State Registrar

				partment of Health and Mertificate of Death	ental Hygier	2006 22201
	Physicia		1. Decedent's Name (First, Middle, Last) Michael M. Vitug			3. Time of Death 17 2006 7:29 PM
5	/Medic Examin		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapolis	7	Anne Arundel
	Funeral Director		5. Social Security Number 575–48–4866 6. Sex 7. Age (In yrs. last birthday 575–48–4866 7. Age (In yrs. last birthday 58 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Oct. 25,	9. Birthplace (State or Foreign Country) Hawaii
	Maryland f show	ior	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I Maryland Queen Anne's	Chester Chester		10d. Inside City Limits 1 ☐ Yes 2™No
	with the	Il Director	10e. Street and Number 104 First Street	10f. Zip Code 21619	10g. (Citizen of What Country?
920	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any Injury or other traumatic event. The Medical Examinational be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Xeyes 2 No If Yes, Give Year or Dates: Vietnam	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 ▼No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within 72 hou iene. 'than "natura the Medical E	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired) Police Officer	ng	Kind of Business/Industry Law Enforcement
Maryland 2	uld be filed Aental Hygi rked other tic event,	To Be Co	17. Father's Name (First, Middle, Last) Ponciano Vitug	18. Mother's Name Rose M	(First, Middle, Maid abon	en Sumame)
	and 2 shouself and No. 27 is mail			ling Address (Street and Number or Rura 104 First Street	I Route Number, City Chester, I	
Baltimore,	Pages 1 ament of He ant: If iten ury or oth	-	1 □ Burlar	ematory or other place) re Crematory 8/24	/2006 Ba	Location - City or Town, State altimore, Maryland
Balt	permit. Departimport any inj			22. Name and Address of Facility Joh 147 Duke of Glouces	_	or Funeral Home Annapolis, MD 21401
H.	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	nter the mode of dying, such as cardiac o		Approximate Interval Between Onset and Death
	Examiner	er	Due to (or as a consequence of): Sequentially list conditions.			
8760,	death certificate be executed e attending physician and id for use as the burial-transit	al Examine	if any, leading to immediate cause. Enter Underlying Cause inter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):			
ox 687	eath certificate attending physi for use as the	/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
.O. B	y th	Physician/Me	in the past 12 months? 1 Live birth 2 Fetel death 3	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
s, P	sign d be	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2₽No 3□Probably 4□Unknown
Record	The law ate has b page 2 si	Completed			24a. Was an autopsy performed 1 Yes 2 2	
Vital	ilcian: certific rector,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death		==0
of	Phys r this ral di	n: To	1 Yes 2 No Tospital. 1 Inpatient 2 ER/Outpati 27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury Injury	of 28c. Injury at 2	ne 5 Hesidence 28d. Describe how in	6 ☐Other (Specify) jury occurred
Division	il or Attending I after death. I Director: After d in by the funer	Certification;	1 Natūral 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, suiciding, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street City or Town, Sta	and Number or Rural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical Ce	29a. Certifier (Check only one) 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or one) 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or one)			
	To the within 2 To the comple	Med	29b. Signature and this of certifier	29c. License number	O 29d. [Date signed (Month, Day, Year)
	4+1		30. Name and address of person who completed cause of death (Item 23a) (Typ	AAMC 2001 M	Alledical Par	nnapolis, MD 21401 rkway
	Sta Registr		31. Date filod (Month, Day, Year) AUG 2 1 2006	ork)		

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 28393 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Helen C. Wishnow рм 19, 2006 August 8:18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 23, 1 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min 1 M 2 F 578-32-2701 95 <u>1</u>911 Director Washington, Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d Inside City Limits 10b County 10a State r then "naturel", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 12914 Acorn Hollow Lane 20906 USA deeth by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ☐ Yes 2 🛣 No Yes. Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎗 ☐ No Specify. White Specify 3€ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home h and Mental Hygie 7 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert Clow Lydia Arnold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan M. Dawson/ Daughter 12914 Acorn Hollow Lane, Silver Spring, MD 20906 item 27 l 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Importent: If its eny Injury or ot ance. 23, t K Burial 2 ☐ Cremation 3 ☐ Removal from State August Rock Creek Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 Washington, DC 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Small Bowel Obstruction /Medical Due to (or as a consequence of) Examiner Ventral Abdominal Hernia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of). Examine or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Septicemia Due to (or as a consequence of): Box 68760. Respiratory Failure Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 90 Urinary Tract Infection, Atrial Fibrillation 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown been sir should I 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 ₩ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospitat: 1 ☑ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No ihis 28a. Date of Injury (Month, Day Year) After the 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Injury 1 Matural 2 ☐ Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide hours after hin 24 hours a the Funeral C npletely filled i Hospital 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 ŝ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059271 30. Name and address Person who completed cause of death (Item 23a) (Type, Print) Keyurkumar A. Shah, M.D. 121 Congressional Lane, #402, Rockville. MD 20852 32. Refistrar's Signature 31. Date filed (Month, Day, Year)

State

Registrar

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2006

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	*		Homewood Nurs				lliams			ington Co.
	Funeral		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday, 89 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours N	Min. (Month, Da	y, Year) C	rthplace (State or Foreign country)
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	yland		10a. State 10b. County		City, Town or L					10d. Inside City Limits
	a-f et	tor	Maryland Washin	igton	Will	iamsport				1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	ath w		16505 Virginia Ave				795		U.S.A	
	er de	Funerai	Tr. Walter States	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of Hi If Yes, specify Cubar	spanic Origin? n, Mexican, Pu	? (Specify Yes or No uerto Rican, etc.)	14. Race - Am Black, Whi	
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State of Maryland / Department of Health and Mental Hygien 2006 28395 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** harlotte Weems 6:50AM ^M AUGUST 23 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TRAPPE TALBOT RAYLAND ACRES If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex Funeral Hours Months Days 1 M 2 XF JULY 8, Director 77 1929 MARYLAND 215-26-5616 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County item 27 is marked other then "naturel", or items 23e or 28e-f show other treumstic event, Ite Mydical Exam per must be mollified at 1 ☐ Yes 🌪 ☐ No Director MD TALBOT TRAPPE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 29160 KRISMORE CT 21673 IISA Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE by 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry permit. Pages I and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Importent: If Item 27 is marked other then "na any injury or other treumatic even." Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be DANIEL G. HIGGINS ANNA D. PEARCE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PO BOX 1383 EASTON, MD 21601 DANNA L. MURPHY/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State CHESAPEAKE CREMATION CTR 8/24/2006 STEVENSVILLE, MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 21. Signature of Funeral Service Licensee OSnough: Joseph 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final DISEASE Physician COVONARY ARTERY 548S disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HTN Sequentially list conditions, if any, leading to immediate auto and the sequence of the sequen Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 40 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' ASSISTED Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 - No his LIVING funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After the Hospitel or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier D040274 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTIN, MD 21601 Com mercer Da 0 8579 Webb

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

			1- State of Maryland / De	partment of Health and Nertificate of Death	Mental Hygie	ene 2006	28396
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici		MARGARET LUCY WEATHERLEY		AUGUST	23 Year 2006	4:50PM M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
ı			700 PORT ST. UNIT 348	EASTON		TALBO	[
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) Count	
	Director		Usual Residence of Decedent		SEPT. 21	1 1923 NEW	YORK
	land ow		10a. State 10b. County 10c. City, Town o.	r Location		10	d. Inside City Limits
	Many a-f sh	ţo	MD TALBOT EAS	TON			1 Yes 2 □ No
	th the or 284	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Count	ry?
	23a 23a ust b	la [700 PORT STREET #348	21601		USA	
	within 72 hours after death with the Maryland ene. then "naturel", or Items 23s or 28s-f show fre Mydical Existing to ast be rediffed at	Funeral		 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
36	s afte	by F	1 ☐ Never Married 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: WHIT	E
21215-0036	ture sture	ed		ecedent's Usual Occupation	16	b. Kind of Business/Ind	ustry
75	nin 72 na "na Medili	plet	(Specify only highest grade completed) (G	ive kind of work done during most of work e. DO NOT use retired)	ring		•
7	d with	Completed		SECRETARY		LIFE INSUR	ANCE
	ba filed Ital Hygi od other event, II	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma	iden Sumame)	
Maryland	should to	은	EDWARD E. KUNERT	LUCY F			
<u>Ja</u>	2 sho		1.1.1	ailing Address (Street and Number or Ru			Code)
	1 and 2 Health tem 27	3		O PORT STREET #348 sposition (Name of		fD 21601 c. Location - City or Tov	un State
סַ	Pages nent of I		1 Burial 2 Cremation 3 Removal from State	crematory or other place)		•	
altimore,			` 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	EAKE CREMATION CTR 22. Name and Address of Facility	8/30/2006	STEVENSVI	LLE, MD
Ba Ba	permit. Departr Importe any inju		Joseph M. Ostranki C.F.S.P	FELLOWS, HELFENBEI 200 S. HARRISON ST	N & NEWNA EASTON,	M FUNERAL I MD 21601	HOME PA
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
E	Pnysician		Immediate Cause (Final disease or condition resulting in death)	ressive brouchi	ectasis	V	Lari
	/Medical Examiner		Due to (or as a consequence of):			/	
		er	Sequentially list conditions, b. Due to (or as a consequence of):				
	utad d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events c.				
ó	be executad sician and burial-transit	Exa	resulting in death) Last C. Due to (or as a consequence of):				
8760,	icate be executad physician and the burial-transit	dical	d				
မ		Med	IF FEMALE:				200000000000000000000000000000000000000
Вох	that the death certificated by the attending I detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3 ☐ Ectopic pregnancy		23d. Date of deliver Month	y Day Year
0	he de the a	yslc	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 Other (specify)			
٥.	The law requires that the death certifi ate has been signad by the attending page 2 should be detached for use as	/ Ph	Part II. Other significant conditions contributing to death bulgnot resulting in the	e underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	cause of death?
Records,	w requires that s been signad t should be det	d by	corenery artery distore	/	1 🗌 Yes	2 No 3 Proba	bly 4 □Unknown
000	w req	Completed	Michtagaryan million	- hillmonare	24a. Was an	24b. Were autop	sy findings available
Re	The lav	mo	which m'	Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan	autopsy performe	prior to com death? 1 \(\) Yes	pletion of cause of
Vital		Φ	25. Was case referred to medical	26. Place of Deat	1 Yes 2 de th (Check only one)	INO I TO 165 A	
	Physiclan: r this certificaral diractor, I	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	tient 3 DOA Other: 4 Nursing Ho	ome 5 XResidenc	ce 6 Other (Specify)	
0 0	ding Ph n. After th funeral		27. Manny of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) Inju (Month, Day Year)		28d. Describe how	injury occurred	
Sio	Attending or death. ector: After by the fune	catl	2 Accident investigation	M 1 Yes 2 No			
Division of	l or Attendate death Director:	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
<u></u>	pitel ours a ieral I		29a. Certifier La Cartifying Physician: To the best of my knowledge, d	eath occurred at the time, date and place	and due to the caus	se(s) and manner as eta	ted.
	To the Hospitel or Attending Physiclan: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only one) Madical Examiner: On the basis of examination and/o and manner stated.	r investigation, in my opinion, death occur	red at the time, date	and place, and due to	the cause(s)
	To the To the To the To the Somple	Me	29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month, D	ay, Year)
})		+ HAVITON IND	D25750	8	124/06	
	5		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)			
			ROBERT B. SANCHEZ, M.D. 508 IDLE	WILD AVE., EASTON,	MD 21601		
	Sta Registi		31. Date filed (Month, Day Year) 2005	hailt o			
	negisti	CII					

	•	For State Registrar	State of Maryla		artment of F rtificate of			giene / Reg. No.	2006	2839
Dhuaisia		1. Decedent's Name (First, Middle, L	ast)				2. Date of De.	ath Day	Year	3. Time of Death
Physicia /Medic		Julia Ann	ne Wilson				68	23	06	0355 M
Examine		4a Facility Name (If not institution, g.	ive street and number)	Center	4b. City, Town, o	r Location of Dear	th		Ounty of Death	
Funeral			Sex 7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th v. Year)	9. Birthp	lace (State or Foreign
Director		219-36-7119	1□M 20XF 66	5 Yrs.	Duy's	Tiodis IIIII	07-25-	1940		ryland
pue *		Usual Residence of Decedent 10a. State 10b. County	10c. C	city, Town or Lo	cation					0d. Inside City Limits
after death with the Maryland or Items 23s or 28s-f show ratings in ust Les notified at	ō									1 🖫 Yes 2 🗆 No
28a-	Director	Maryland Talbo	ot	Easton	10f. Zip Code			10a Citiza	en of What Cour	ntry?
with Sa or						. 1				,.
heath rns 23	Funerai	420 August St	12. Was Decedent Ever in		2160 Was Decedent of H	lispanic Origin? (S	Specify Yes or No	- 14	USA Race - Americ	an Indian,
or iter	F	1 Never Married 2 ☐ Married	Armed Forces?		f Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)		Black, White,	etc.
Si - Si	<u>م</u>	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		S	Specify: R	lack
"natur	Completed	15. Decedent's (Specify only highest g	Education		dent's Usual Occup		orkina	16b. Kine	d of Business/In-	
d within 72 piene. r than "nat	n pie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	g			
filed wi Hygien other th	Co	10		Co	ok				ain Ale	K
d oth	Be	17. Father's Name (First, Middle, Las	it)			18. Mother's Na	me (First, Middle,	Maiden S	umame)	
5 0 X 5	2	Horace Melvir					Elizabeth			
O. 00 30 50		19a. Informant's Name/Relationship		19b. Maili	ng Address (Street	and Number or R	ural Route Numbe	er, City or	Town, State, Zip	Code)
s 1 and 2 if Health Item 27 i		Karen Wilson			August St		aston, Mar			State State
96 of 10 of		20a. Method of Disposition 1 Burial 2 □ Cremation 3	LINGINOVALITOIN STATE	cemetery, crei	sition (Name of natory or other place	ce)	Date	ZUC. LOC	ation - City or To	own, State
		4 Donation 5 Other (Spec					30-2006	Gras	onville	Maryland
permit. Pag Department Important: eny injury o		21. Signature of Funeral Service Lice	ensee	22	Name and Addre		neral Hon	ne	426 Dov Easton	ver Street Md. 21601
		23a. Part1. Enter the disease or co shock, or heart failure. Eist on	mplications that caused the dea y one cause on each line.	ath. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory ar	rest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	ASC	UD)					Onset and Death
/Medical		resulting in death)	Due to (or as a conse	quence of):				~		
Examiner		Sequentially list conditions	b. nepln	otii.	Junales	mes	lus to	Du	shete	,
pe sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):	/					
cate be executed physicien and the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as a conse	iguence of):						
be ed icien buria				4						
phys phys s the	dical		d						1	
death certificate attending place as t	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregr	nancy				23	d. Date of delive	NTV
atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fei 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)	1		-	Month	Day Year
0 0 0	ys	1 ☐ Yes 2 ဩNo 9 ☐ Unknown	9□ Unknown							
= 00	by P	Part II. Other significent conditions	contributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco us	e contribute to the	ne cause of death?
quires n sign							101	/es 2 🗌	No 3 ☐ Prob	ably 4 Xunknown
w requir been si should	Completed						24a. Was	an	24b. Were auto	psy findings available
The lav	Ĕ						autop perfo	rmegr?	death?	psy findings available inpletion of cause of
fcian: T certificat rector, pa		25. Was case referred to medical				26 Place of De	1 ☐ Yes ath (Check only o	2 No	1 🗆 Yes	2 L No
	To Be	examiner?	Hospital: 1 Inpatient 2[ER/Outpatier	t 3 DOA Oth		Home 5 ☐ Resid		Other (Specifi	4 1
9 Physer this eral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe			//
Attending Part death. ector: After by the funer.	at io	1 X Natural 5 ☐ Pending 2 ☐ Accident investigati		Injury		Yes 2 □No				
al or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not 4 Homicide determine		home, farm, str	eet, factory, office		28f. Location (S City or Tox		Number or Rura	l Route Number,
spital or ours afte neral Dir filled in I	Cert	- I Tolling	ballaring, etc. (Spec	y/			Only of 100	m, otate/		
Hospi 4 hour Funer ely fill	edical		Physician: To the best of my kraminer: On the basis of examinand manner stated.							
# 5 # ₽	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date	signed (Month,	Day, Year)
		1	7	20	HI	057	10	D	123/	26
	1	30. Name and address of person wh	o completed cause of death The	om 23a) (Type.	Print)		10 mo	/		76
2.		Simona Eng	IM E. Cari	7115	t. 50%	Shire	MP -	2181	2/	
Stat	e	31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature		sury		2106		
Registra		AUG 28 2	006	An A						

DHMH 17 Rev 1/2001

219-36-7119

Wilson

State of Maryland / Department of Health and Mental Hygien [] [] [28398 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month **Physician** AUGUST 21, 2006 7:00 A M WAUGH /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** CECIL SUNBRIDGE CARE AND REHABILITATION ELKTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEP 13, 19 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Days Months Hours 1 ☐ M 25 ☐ F 1909 BARBOURSVILLE, WV 96 Director 221-16-7146 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 28a-f show rthan "natural", or items 23a or 28a-f shov the Wedical Examiner must be notified at 1 ∑Yes 2 □ No Director ELKTON CECIL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21921 USA 1 PRICE DR Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exercising Once. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FOOD PREPARER CATERING 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be NEVADA GILKINSON CLAY WILLIAM 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DAUGHTER BEAR, DE 19701 DONNA HITCHENS, 12 VISCAYA DR 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🎇 Burial 2 □ Cremation 3 💢 Removal from State AUG 25, 2006 NEW CASTLE, DE GRACELAWN MEM PARK ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SPICER-MULLIKIN FUNERAL HOMES INC 21. Signature of Funeral Service Licensee 1000 N DUPONT HWY NEW CASTLE, DE 19720 23a. Part . Enter the disease, or complications to shock, or heart failure. List only one cause Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) 10 THRIVE ANIURE **Physician** /Medical Due to (or as a consequence of): Examiner Demonto Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has l autopsy performe 2/2 No certificate 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 Inpatient this Date of Injury (Munth, Day Year) After thi 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident hours after death Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pl. ce of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funaral I 12 Certifyin: Physicia To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Taminer: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 1754073 30. Name and address of period why completed cause of death (Item 23a) (Type, Print) 817 CHURCHMANS OR NEWLASHE 20 32. Reg trar's Signature 31. Date filed (Month, State 2006 Registrar

			For State Registrar	State of M	larylan				lealth a Death		ental Hy	Reg. No.	/ 1 1 1 1 1		2839
	Physici	an	1. Decedent's Name (First, Middle, Las	t)							Month	Day	2006		3. Time of Death
	/Medio		Vernon Lee Ward 4a. Facility Name (If not institution, give	street and numbe	r)		4b. City	, Town, or	Location of		August		County of D	eath	J. JU A
	Examir	ier	Washington Advent:				Tak	oma I	ark			M	ontgon	nery	
Ž	Funeral Director		5. Social Security Number 6. Security Number 12			last birthday) 8 Yrs.	If Under	Days	If Under Hours	Min	8. Date of Bi (Month, D Apr. 1	av. Year	9. 928 Mi	Birthpla Country LSSO	ce (State or Fore y) uri
	Maryland a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge	eorge¹s		y, Town or Lo	ocation							100	1. Inside City Lim 1 ☐ Yes 2 🛣
	or 28	Director	10e. Street and Number					ip Code				10g. Cit	izen of What	Countr	y?
	23a	rai	8708 Reicher Stree					785				USA			
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show eny injury or other traumatic event, 12s Medical Examinar must be notified at ance.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force: 1 To Yes 2 [If Yes, Give Year or Dates	s?] No			edent of Hecify Cuba	lispanic Ori an, Mexicar Specify:		crfy Yes or N Rican, etc.)		14. Race - A Black, W Specify: B1	/hite, et	C.
9500-61717	ithin 72 ho ie. ien "natur Medical	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	de completed) College (1-40	r 5+)	(Give	kind of w DO NOT	use retired	during mos d)			16b. K	ind of Busine	ss/Indu	stry
N	ygien ygien r,	Con		2		Elect	roni	c Dat				1	. Trea	sur	У
Maryland	uld be fill Menta! H arked oth	To Be	17. Father's Name (First, Middle, Last) Willis Andrew Ward	1					Este.		(First, Middle Cain	e, Maiden	Sumame)		
Mar	alth and alth and alth and alth and alth and alth and alth alth alth alth alth alth alth alth		19a. Informant's Name/Relationship (7 Clemmie E. Ward/w				-				dover,				(ode)
galtimore,	Pages 1 aent of He nt: If Item ry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		Place of Dispo cometery, crea sapeak) Ale		sville		_{n, State} ary1and
סמונו	permit. I Departm Importal eny injui		21. Signature of Funeral Service Licen		-	G	2 Name Oing	and Addre Home	ss of Facili	matic	n Serv	rice	P.O.	Box	
, no./	os that the death certificate be executed Washington and physician and be detached for use as the burial-transit	dicai Examiner	23a. Part 1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a Du	as a consequence as a c	Shelic (uence of): wosc					OVASA		dir		nterval Between Onset and Death
r.O. DOA 08	the death certifica y the attending ph sched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Feta at time of d	al death 3	⊒Ectopic ⊒ Other (pregnancy specify)	/				23d. Date of Month		/ Day Year
	requires that the een signed by th nould be detache	þ	Part II. Other significant conditions o	ontributing to death	but not res	sulting in the u	ınderlying	cause giv	ren in Part I	1.					cause of death
S E	> 0 50	Completed									per	s an opsy formed? 2 No	prior	to com	sy findings available for the system of cause
<u> </u>	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Oth		e of Death	(Check only	one)			
0 0	ng Physician: Viter this certific uneral director,	on; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of li		28b. Time of Injury	of	28c. Injur Wor	y at rk?		me 5 Res 28d. Describe			Specify)	
DIVISION OF VITAL	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	9 28e. Place of	Injury - At h etc. (Specia	ome, farm, st	M reet, facto		Yes 2			(Street ar own, State		r Rural	Route Number,
	ne Hospit ne Funera letely fille	edical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exertion)	nysicien: To the be niner: On the basis and manner	of examina	owledge, dea ation and/or in	th occurre	d at the tir	me, date ar opinion, dea	nd place, ath occurr	and due to the	e cause(s e, date an) and manne d place, and	r as sta due to t	ted. the cause(s)
	To the To the COMP	Me	29b. Signature and title of certifier	p	20				se number	100	7		te signed (M		
*	102		30. Name and address of person who	completed cause of	of death (Iter	m 23a) (Type	Print)	831	Uni	VERS,	ty Blu	d, E	#2	5	No 2090
	St Regist	ate	31. Date filed (Month, Day, Year) ALIG 2 4 2	1006 32. Togi	strar's Sign	ature	hast				1	,			

DHMH 17 Rev 1/2001

			For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artment o	f Health of Death	and Me	ental Hy	giene / Reg. No.	2006	28400
	# E		1. Decedent's Name (First, Middle,	Last)						2. Date of De.	ath		3. Time of Death
	Physici /Medio		Veryl Eugene	Weimer					I A	Month August	Day 23	2006	3:50 P ^M
	Examir		4a. Facility Name (If not institution,	give street and no	umber)		4b. City, Tow	n, or Location			4c. C	ounty of Death	
			Holy Cross Hosp	oital			Silve	r Spri	ng		Me	ontgome	rv
	Funeral			6. Sex	7. Age (In yrs.	last birthday)		ar If Under	r 24 Hrs.	8. Date of Birt (Month, Da	h	9. Birth	place (State or Foreign
	Director		218-12-5126	1 M 2 □ F	82	Yrs.	Working Da	75 110410		May 19,			yland
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation						10d. Inside City Limits
	•ho	5											1 ☐ Yes 2√∑ No
	28a-f	Director	MD Garre 10e. Street and Number	tt		Mtn. L.	ake Par				40.00		**
	with o	급					10f. Zip Coo					on of What Cou	•
	death with the Maryland rme 23a or 28a-f ehow r must be notified at	Funeral	211 Roanoke Ave		cedent Ever in U	IS 13 1	_1	1550	rigin? (Spec	rifu Ves or No		ed Stat I. Race - Ameri	
_	lter d	Ë	1 ☐ Never Married 2 🕅 Marrie	Armed F	orces?	7.5.	Was Decedent If Yes, specify (Suban, Mexica	an, Puerto R	ican, etc.)	. '	Black, White,	
2	urs al	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or	2□No ive Dates: WWII		1□Yes 2🛣	No Specify	/ :		s	Specify: LTh	ite
212-0030	etur	ted	15. Decedent's	s Education		16a, Dece	dent's Usual Oc	cupation			16b. Kind	of Business/Ir	
2	hin 7	Completed	(Specify only highest Elementary/Secondary (0-12)) (1-4or 5+)	life.	kind of work do DO NOT use re	ne during mos tired)	st of working	g			
7	d wit	OIT	12	oom og o ((, 10, 0,)	Ca	rpenter				Cons	structi	on
and	oth oth	ВеС	17. Father's Name (First, Middle, L	ast)				18. Moth	ner's Name ((First, Middle,	Maiden S	umame)	
<u>a</u>	should be fand Mental Fermanked of	To	Jacob H. We	imer				1	Nellie	2	imme	rman	
a	and h		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address (Str	eet and Numb	ber or Rural	Route Numbe	or, City or	Γο w π, State, Zij	Code)
Σ	and 2 valith v 27 i		Mrs. Ruth Weime	r, Wife		211 1	Roanoke	Ave.,	Mtn.	Lake F	ark,	MD 215	50
e e	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel; or Iteme 23a or 28a-f show appring to other traumatic event, the Medical Examinat must be notified at once.		20a. Method of Disposition	2	,	Place of Dispo	sition (Name or	olace)	Da	te	20c. Loca	ation - City or To	own, State
Ĕ	Page nent int: If		1 🖾 Burial 2 ☐ Cremation : 4 ☐ Donation 5 ☐ Other (Sp.		State		Cemeter		8/28/	06	0ak	land, M	D
altimol	permit. Departn Imports any inju		21. Signature of Fineral Service L	icensee)	L							Funeral	
מ	88 188	y 4	World h	1. 13 W	DOOR		2	1 N. Se	econd	St. C	aklar	nd, MD	21550
			23a. Part . Enter the disease, or of shock, or heart failure. List of	omplications that	caused the dea	th. Do not ent	er the mode of	tying, such as	s cardiac or	respiratory ar	rest,	14, 112	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_									Onset and Death
	/Medical		resulting in death)		psis (or as a consec	quence of):							
	Examiner		One and the link and distance	ь En	d Stage	Multi	ole Mvl	oma					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a consec		/-						
	cuted nd ransi	Examiner	that initiated events	С.									
Ď	exe en ar	Ä	resulting in death) Last	Due to	(or as a consec	quence of):							
0/00,	cate be executed physicien and the burial-transit	dicai		d									
0	ng ph ng ph	Med	IF FEMALE:								- 1		
XOD D	th ce tendii r use	an/	23b. Was decedent pregnant		stcome of pregn birth 2 Pet		Ectopic pregna	ncv			23	d. Date of delive	•
	dea deafo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of o		Other (specify					Month	Day Year
5	at the	Physician/Me	9 🗆 Unknown										
'n	w requires that the death certif been signed by the ettending should be detached for use as	by	Part II. Other significant condition	s contributing to o	death but not res	sulting in the u	nderlying cause	given in Part I	1.	23e. Did to			he cause of death?
necords,	equir en si ould	fed	Dementia				_			1 🗆 Y	es 24	No 3 ☐ Prot	pably 4 □Unknown
ပ် သ	as be	Completed	Renal Fai	1ure						24a. Was autop	an	24b. Were auto	ppsy findings available mpletion of cause of
ב	sicien: The law s certificate has b lirector, page 2 s	Ю								perfor	med? 2 X No	death?	
<u> </u>	ien: rtifica	Be	25. Was case referred to medical examiner?					26. Place	e of Death (Check only o			
_	nysic nis ce direc	70	1 ☐ Yes 2 X No	Hospital: 1 📉	Inpatient 2	ER/Outpatien	t 3 DOA	Other: 4 🗆 Nu	ursing Home	e 5 🗆 Resid	ence 6[Other (Specif	ν)
5	ng Pl		27. Manner of Death 1 Anatural 5 Pending	28a. Date	of Injury oth, Day Year)	28b. Time of Injury	28c. li	yury at Vork?		d. Describe h			
VISION	andir ath. or: Af	atic	2 ☐ Accident investiga	ation	, , , , , , , , , , , , , , , , , , , ,	,,		☐Yes 2☐]No				
<u> </u>	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and 289. Place	e of Injury - At h ling, etc. (Speci	ome, farm, str	eet, factory, offi	ce	28	If. Location (S City or Tow		Number or Rura	al Route Number,
5	rs eft	Cer								0.1, 0 0.1	in, Gialoy		
	To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours elter death. within 24 hours elter death. To the Funeral Director. After this certificate has been signed by the estending is completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier (Check only 2 Medical E	Physician: To the xaminer: On the b	e best of my kno	owledge, death	occurred at the	time, date ar	nd place, an	d due to the d	ause(s) ar	nd manner as s	tated.
	the Hin 24 the Fiplete	Medical	one,	and mar	ner stated.	and/or in				at the time, (ate and pl	ace, and due to	trie cause(s)
	To To Com	2	29b. Signature and title of certifier	1.	7 . 0		29c. Lice	ense number			29d. Date :	signed (Month,	Day, Year)
			> Ks han	ia no	7		D60	0826			8/24	/06	
5.	+VA		30. Name and address of person w	ho completed cau	se of death (Ite	n 23a) (Type,	Print)						
ר (, , , ,		Dr. Kshama Garg				oital, 1	500 Fo	orest	Glen R	d., S	ilver S	Spring, MD
	Sta		31. Date filed (Month, Day, Year) AUG 2		Registrar's Signa	ature							
	Registr	ar	AUG &	of COOD		AND THE REAL PROPERTY.	A N.						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 28402 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Year **Physician** BABY MALE ASEBIODENOAH 2035 2006 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE Horge s' Hospital GEORGE'S 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits if Health and Mentel Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumstic event, the Medical Examiner must be notified at HYATTSVILLE 1 Yes 2 No Director PRINCE GEORGE'S 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20785 DODGE 3320 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: þ BLACK Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INFANT INFANT 0 permit. Pages 1 end 2 should be filed.
Department of Health end Mentei Hygi important: If Item 27 is marked other any injury or other traumestance. 17. Father's Name (First, Middle, Lest) unk 18. Mother's Name (First, Middle, Maiden Surname) Be ASESIODENOAH OLUWAKEMI 19a. Informant's Name/Relationship (Type, Print) (MOTHER) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) OLU WAKEMI ASEBIODENOAH 3320 DODGE PARK KD HYATTS VILLE MD 20185 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 NOther (Specify) in state 21. Signature Funeral Se vica Licensee Ronald S. Wad 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director <u>Baltimore</u>, MD 21201 | BAITIMORE, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as Physician/Medical Examiner physician end s the buriei-trensit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last P.O. Box 68760, Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 No 3 Probably 4 Unknown Division of Vital Records, Be Completed by pege 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Ves 2140 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 □ Yes 1 (Inpatient 2 ER/Outpatient 3□ DOA this 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 UNatural 5 Pending investigation 24 hours efter death. 1 Yes 2 No 2 Accident 6 Could not be determined within 24 hours efter dea To the Funeral Director completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only ţ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who simpleted cause wheeth (Item 23a) (Type, Print) I An I MA C JENNINGS; 2001 Hospital

32. Registrar's Signature

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiens, 28403 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Michael L. Apson August 26, 2006 5:15 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care of Towson Towson Baltimore If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Mar 23, 19 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. 1 ☑ M 2 ☐ F Months Hours Director 60 1946 218-44-9587 Maryland Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23e or 28a-f show the Medical Examiner must be notified at MD 1 Yes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2325 Hollins Street 21223 death Funerai USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2 f Yes, Give 1 Never Married 2 Married 2 XNo Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: black 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 auto worker General Motors other treumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 Is marked otherny injury or other treumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LaVerna Apson ပ Lizzie Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Apson/spouse 2325 Hollins Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 14 X Donation 5 ☐ Other (Specify) 21. Signatule of Funeral) ervice Licensee Royald S. W 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street irector Baltimore, MĎ 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician 10+16/051 disease or condition resulting in death) years /Medical Due to or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by heart tailure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 NO 1 Yes 1 Yes 2 Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 Yes 2 No 2 this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. 2 Accident investigation Director: 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0006/199 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Suite 209, Towson MD 21204 Noin Charles 6565 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Victoria Ascione 4:22pm September 5,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Futurecare Chesapeake Arnold If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month Day Year) May 6,1919 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 162-54-9498 1 ☐ M 2 🔀 F 87 Yrs. Director New Castle, PA Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ehov ampy njury or other traumatic event, if a Medical Examinar must be notified at once. MD Anne Arundel Arnold 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 College Parkway 21012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 DYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2N No ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Pagley Catherine Carvella 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Raymond Ascione/Son 1652 Canonade Court Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State New Castle, PA St. Vitus Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature o Funeral Service Licensee 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 East Fort Ave. Baltimore MD 21230 23a. Part1. Enter the disease, or complica shock, or heart failure. List only one tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onself and Death **Physician** morria des /Medical Examiner 01 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregrant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ō Month Day 4☐Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 4 Dunknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA After the funeral of 28a. Date of Injury (Month, Day Year) 27. Manna of Death 28b. Time of Injury Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: d in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funeral (To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Hwy Millers who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mong. Pap State Registrar

ORIGINAL

			1 - For State Registrar		State of N	Maryland / De C	oartmen e <i>rtificat</i>			d Mental H		2006	28405
	Physic	ian	Decedent's Nam	e (First, Middle, L	.ast)	211				2. Date of I	_	Day Year	3. Time of Death
	/Medi	cal	4a Fecility Name (4 bu	ive street and number	ngni	4b Cibe	Town or I	Location of D			4c. County of Death	1:00 PM
	Exami	ner		Hospita		")	4b. City,		Ltimore			c. County or Deat	n NT / A
	Funeral		5. Social Security N		Sex 7.	Age (In yrs. last birthda	y) If Under Months		If Under 24		Birth	9. Birti	N/A hplace (State or Foreign untry)
	Director		220-30-6		1 M 2 F	70 Yrs.	Months	Days	Tiours	Jul.	23,		Maryland
	land ow		Usual Residence of 10a. State	10b. County		10c. City, Town or	Location						10d. Inside City Limits
	e-f sh	tor	MD	Ann	e Arundel	G	Len Bui	rnie					1 ☐ Yes 2 € No
	or 28	Funeral Director	10e. Street and Nu	mber			10f. Zip	Code			10g. 0	Citizen of What Co	untry?
	s 23a	ral	1127 McH	enry Dri					21061			United S	
10	ter de inern	-une	11. Marital Status	ied 217 Married	12. Was Deceder	5 !	If Yes, spec	lent of His offy Cuban	spanic Origin? n, Mexican, Pi	? (Specify Yes or I uerto Rican, etc.)	No-	14. Race - Amer Black, White	
5-0036	72 hours after death with the Maryland natural', or items 23a or 28e-f show dical Exat in wr must be multihed at	by	3 Widowed		1 ☐ Yes 2 € If Yes, Give 4 Year or Date:	S:	1 ☐ Yes 2	2₹ No	Specify:			Specify: W	hite
5-0	72 ho	Completed	(Spec	15. Decedent's	Education rade completed)	(Gi	edent's Usua e kind of wor	k done du	tion uring most of	working	16b.	Kind of Business/I	ndustry
121	filed within Hygiene. Ither than "	mpl	Elementary/Seco	ndary (0-12)	College (1-4o	life	. DO NOT us	se retired)		,			
d 21	filed Hygir other ent, I		17. Father's Name	(First, Middle, La:	st)		Electr			Name (First, Midd	le, Maide	Westingh	ouse
<u> a</u>	Aental Aental rked c	To Be	Woodrow !	W. Harve	V				Sar	ah Jane	Smit	·h	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylar to Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-f show or other traumatic event. The Medical Exact in arringst by rudified at		19a. Informant's Na				iling Address	(Street ar				or Town, State, Z.	ip Code)
	of Health of Health item 27				ht, Sr. H		7 McHe	enry	Drive,			MD 210	
Baltimore,	Pages '		20a. Method of Dis	Cremation 3	Removal from State	20b. Place of Dis cemetery, c West Ar	ematory or of	ne or ther place,)	Date	20c.	Location - City or 1	Fown, State
Ē		1	° 4 ☐ Donation	Other (Spec			22 Grenz	tory	of Facility	11-2006	_00	lenton, M	D
B	permit. Departr Imports any inft		No	but	Karn	uy !	Control Control	1000 1000				neral Hom	
			23a. Pert1. Enter to shock, or hea	ne disease, or contraction	mplications that caus	ed the death. Do not e	nter the mode	or dying,	ur Spr such as card	ino Rd diac oprespirator	arrest,	outus, M	1122 ate Interval Between
	Pnysician		Immediate Cause disease or condition	Final	Pulm		Embo	lisu	\sim				Onset and Death
	/Medical Examiner		resulting in death)	-	Due to (or a	is a consequence of):			•				
		er	Sequentially list contains, leading to make cause. Enter Under Cause (Disease or	nditions,	b. Due to (or a	is a consequence of):							
	uted d ansit	Examiner	cause. Enter Under Cause (Disease or that initiated events	rlying injury	c	. ,							
oʻ	cate be executed oblysician and the burial-transit		resulting in death) I			s a consequence of):							
8760,	physics the bi	dica			d								
Вох 6	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceden	prognant	23c. If yes, outcom	e of pregnancy						23d. Date of deliv	VOD.
B	death e atter	iclar	in the past 12	months?	4☐Pregnant		☐Ectopic pre☐ Other (spe					Month Month	Day Year
P.O	that the de ed by the a detached t	hys	1 □ Yes 2 9 □ Unknown		9□ Unknown								
ŝ	res tha igned be de	by	Part II. Other signif	icant conditions	- %	but not resulting in the	underlying ca	iuse given	in Part I.			V	the cause of death?
orc	w require been si should b	eted	Coron	Overs	20 000	<i>-</i> 44 04	VUT			- 1L	Yes a	2 ZN o 3□Pro	bably 4 Unknown
Rec	ne law has b	Completed								24a. Wa aut	s an opsy formød?	24b. Were auto prior to co death?	opsy findings available ompletion of cause of
		e Co	25. Was case refer	red to medical	1				OC Diago of F	1 ☐ Yes	2 XN		2 No
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0 L	ding Ph h. After th funeral		27. Manner of Death	n 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. Time		c. Injury a Work?		28d. Describe			-97
sio	r Attendi er death. rector: A by the fu	catle	2 Accident	investigation 6 Could not	ho		М	1 🗆 Ye	es 2□No				
Division	I or Attend after death Director:	Certification:	4 Homicide	determine	289. Place of I	njury - At home, farm, s atc. <i>(Specify)</i>	treet, factory,	office		28f. Location City or To	(Street a own, Sta	and Number or Run te)	al Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier	1 Certifying P	hysician: To the bes	t of my knowledge, dea	ith occurred a	t the time	, date and pla	ace, and due to the	a cause(s) and manner as	stated
	he Ho n 24 h he Fu oletely	edical	(Check only one)	2 Medical Exa	miner: On the basis and manners	of examination and/or	nvestigation,	in my opir	nion, death o	ccurred at the time	, date ar	nd place, and due t	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and	title of certifier				License r			29d. D	ate signed (Month,	Day, Year)
•	5		* KU+	rent	my) 3°	Nele	0	9	-7-(ما ٥
K)		30. Name and address	_	completed cause of	death (Item 23a) (Type	, Print)		B. 1	Himere	L A	ND 21	720
	Sta	te	31. Date filed (Mont			trar's Signature	7	704.	• 100	MOYO	V	vi 21	0.70
	Registr			SEP 08	2006		1 -00	***					
DHN	JH 17 Rev 1/20	001				May 10.		9					
						ORIGIN	AL						

State of Maryland / Department of Health and Mental Hygiene 28406 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav John Carpenter Atkinson-Maitland 6:16 a September 3, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard Columbia 6159 Campfire 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 □ F Days Hours Director 78 220.24.3669 Usual Residence of Decedent September 3, 1928 MD the Maryland 10b. County 10a State 10c. City, Town or Location 17 le marked other then "natural; or Itema 23a or 28a-f ehow traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21045 by Funerai 6159 Campfire 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ited within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1953 1 ☐ Yes 2 ☐ XNo Specify White 3 ☐ Widowed 4 ☐ Divorced 1955 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. education Elementary/Secondary (0-12) College (1-4or 5+) educator permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy, important: If Item 271e marked any injury or other to once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mildred Dyke John C. Maitland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6159 Campfire Columbia, Maryland 21045 Ms. Marilyn Maitland Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/06/2006 Ellicott City, MD St. John's Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 ambellen MOUSIS 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of of pregnancy 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth in the past 12 months?

1 Yes 2 No 3 □Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown s been signed by th 2 should be detache 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate Division of Vital 1 Yes 2 No to the Hospital or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death | Check only e Hospital: Other: 4 Nursing Home မှ 1 ☐ Yes 2 NO 1 Inpatient 2 ER/Outpatient 3□ DOA 5 V Residence 6 □Other (Specify) this After thi 27. Mann Death 28a. Dale of Injury (Month, Day Year, 28c. Injury al Work? Medical Certification; 28d. Describe how injury occurred 1 Matural 5 Pending investigation within 24 hours after death.
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier eath (Item 23a) (Type, Print) o care 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

SEP 0 8 2006

Registrar

State

COURT

GASS

GLD

MIRCEA TODOR

ROAD

RANDALLSTOWN MD 21133

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8401

32. Registrar's Signature

Post : 26.8

HOSPITAL

SEP 0 8 2006

NORTHWEST

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2006 28408 Certificate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Vladimir Babushkin 0050 M SEPTEMBER 3 2006 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SINAI HOSPITAL OF BALTIMORE BALTIMORE CITY N/A | Months | Days | Hours | Min. | AUG | 8, 1951 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral №** M 2□ F 55 272-04-5427 Director Russia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 17 Is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Examinar must be notified at 10d. Inside City Limits Yes 2□No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Cobblestone Ct 21215 Russia Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ Specify Specify White 3 ☐ Widowed X☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than College (1-4or 5+) 5+ Elementary/Secondary (0-12) Owner Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Anatolie Babushkin Alexandra Tarasova 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Artem Babushkin/Son 1 Cobblestone Ct #T1 Baltimore, MD 21215 Heelth i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 9/7 Baltimore, MD 21. Signature of Funeral Service-22. Name and Address of Facility
Cremation Society of Maryland, Inc. C. Todd Dring 7.11 E 299 Frederick Rd Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS 106 days /Medical Due to (or as a consequence of): Examiner 3 months CHOLANGIOCARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine attending physicien and for use as the burial-transit certificate be executed Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 3 Probably 4 □Unknown Completed 2 □ No been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐No certificete 1 Yes 2 □ No Attending Physician: 25. Was case referred to medical 26. Place of Death Check only one examiner? 1☑ Yes 2☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this ieral Director: After th filled in by the funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide 5 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature/and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 he MBBS SEPTEMBER 3, 2006 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) PRITAM NEUPANG SINAI HOSPITAL OF BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 8 2005 ED ()

06-06286 Tyrone Barnes

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

one De			1- For State Registrar		ertificate of		a went		Reg. No 20	06 2841
Pi dical	nysicia Evami		Decedent's Name (First, Middle,L	ast)				2. Date of De Month August 2		3. Time of Death 1237 hrs
aulcai i	LAGIIII	IICI	Tyrone Barnes 4a. Facility Name (if not institution,	give street and number)		1b. City, Town, or	Location of		4c. County of E	
			Johns Hopkins Bayview			Baltimore				
	neral ector		UIIK	Sex 7. Age (In yrs XM 2 F 51	last birthday)	If Under 1 Year Months Day		Min.		e. 8irthplace (State @nk oreign Country)
	×		Usual Residence of Decedent 10a. State 10b. County	100 Cit	y. Town or Locati		·			10d Inside City Limits
	28a-f show any		10a. State 10b. County		1timore	OII				1 X Yes 2 No
yland	a-f sh	ţċ	10e. Street and Number			10f. Zip Code			10g. Citizen of What	
n the Man	3a or 28 otified a	Director	5117 Benton He	ights Avenue			2120		US	•
eath wit	items 2 ust be n	Funeral	11. Marital Status 1 Never Married 2 Marri	ed 12. Was Decedent Ever in the Armed Forces?				in? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race - A White, e	merican Indian, 8lack, tc.
after d	al", or iner m	by Ft	3 Widowed 4 Divorc	ted If Yes, Give Year or Dates:		Yes 2X No			Specify:	black
hours	natur	edi	15. Decedent's Education (Specify		16a. Deceden during m	t's Usual Occupa ost of working life	tion (Give k	kind of work done un use retired)	16b. Kind of Busin	ess/Industry un
36 in 72	han "	plet	Elementary/Secondary (0-12)	College (1-4 or 5+)						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland	Health and Mental Hygiene item 27 is marked other traumatic event, the Mee	Be Completed	unk 17. Father's Name (First, Middle, La	unk st)	J	unk	18.Mother's	s Name (First, Middle,	Maiden Surname)	unk
21; ould b	is mar	To	19a. Informant's Name/Relationship	(Type, Print)				ber or Rural Route Nu		State, Zip Code)
MD rd 2 sh	of Health and I If item 27 is r ier traumatic		O.C.M.E.	Look				Sltimore, N		0.11
Baltimore,	nt of Heat it: If ite		20a. Method of Disposition 1 8urial 2 Cremation	3 Removal from State	Place of Dispos crematory or oth		metery,	Date	20c. Location - Ci	ty or Town, State
time t. Pag	tment rtant: r or of		4 Donation 5 NOther Spec	ify: in state	- Loo 1					
Bal	Department of I Important: If injury or other		21. Signature of Eureral Service Linkonald	Wade, Directo	r St	ate Anat Ltimore,	omy B	oard 655 W 21201	. Baltimo	re Street
Phys	sician			mplications that caused the deat					rest, shock, or heart	Approximate Interval
	edical miner		failure. List only one cause on Immediate Cause (Final disease	a. Complications of Cirrh	osis					8etween Onset and Death
LAdi	IIIIIei		or condition resulting in death)	Due to (or as a consequence						
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence		<u> </u>			_	
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	с						
ited	ansit		events resulting in death) Last	Due to (or as a consequence d.	or):					1
760, cate be executed	physician and the burial - transit	Medical	UNPENDED	AMENDED						
760, icate be	physic the bu		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre			m		23d. Date of de	•
Box 68'	e attending for use as t	/sician	past 12 months?	1 Live birth 4 Pregnant at time of o	da ath	tal death 3 her (Specify)	Ectopic	pregnancy	Month	Day Year
Bo)	the att	Physi	1 Yes 2 No 9 Unkno	9 Unknown		110, (=,===.,,				
o.	2 G	by P	Part II. Other significant condition	s contributing to death but not	resulting in the u	inderlying cause	given in Pa	· · ·		te to the cause of death? Probably 4 Unknown
IS, P.	pe Si							24a Was		re autopsy findings available
Orc law re	has been 2 2 should	Completed		<u> </u>				auto		r to completion of cause of
Re(his certificate director, page	Con				20.51	(5 "	1 Yes		Yes 2 No
ital sician	this certificate I director, page	Be	25. Was case referred to medical examiner?	Hospital: 1 / Inpatient 2	ER/Outpatient		Other	(Check only one) Nursing Home 5	Residence 6	Other;
of Vital Records,	After th	.: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of I		ry at Work		how injury occurred	
ion		atior	1 Natural 5 Pending 2 Accident Investig			1	Yes 2	No		
Division	24 hours after death Funeral Director: tely filled in by the	Certification:	3 Suicide 6 Could reference determ	oot be 28e. Place of Injury - At	home, farm, stree	et, factory, office l	building, etc	c. 28f. Location or Town,		or Rural Route Number, City
Division of Vital Records, P.O. Box 68 ⁻ To the Hospital or Attending Physician: The law requires that the death certifi	within 24 hou To the Fune completely fi	Medical C	29a. Certifier 1 Certifying Phys	sician: To the best of my knowle						
To	To COT	Me	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date signed	(Month, Day, Year)
			30. Name and address of person w	completed cause of death (Ito	llehr m 2321	o.c.	M.E.		August 23, 20	006
			Patricia Aronica-Pollak	· ·	•	111 Penn S	treet, Ba	ltimore, MD 2120	01	

State 31. Date filed (Month, Day, Year) SEP 0 8 2006 Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certificate of Dea		7.0	g. No. 200	6 2811
Physici Medical Exami		Decedent's Name (First, Middle, Antonio	Raheem		Brown	Date of Death Month September		3. Time of Death 0147 hrs
		4a. Facility Name (if not institution,	give street and number)	4b. City	, Town, or Location of Dea		4c. County of Death	
F		St. Agnes Hospital 5. Social Security Number 6	Sex 7. Age (In yr		timore	ra IO Data of Birth	- AMARD DANGO O Di	dhalaa (Shaha
Funeral Director				Mor	nder 1 Year If Under 24H hths Days Hours Mi		h(MM/DD/YYYY) 9. Bir Foreig 3 90 Co	
		Usual Residence of Decedent				07 1.	3 90 30	1115
ow any		10a. State 10b. County		City, Town or Location				10d. Inside City Limits 1 XYes 2 No
daryland 28a-f show any 1 at once.	Director	MD NA 10e. Street and Number		Baltimore 106.2	Zip Code	10	g. Citizen of What Cou	
5-0036 lied within 72 hours after death with the Maryland Hygiene other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Dire	4215 Ethland	Ave		21207		U.S.A	٨.
ath with tems 2:	Funeral	11. Marital Status 1 X Never Married 2 Mari	12. Was Decedent Ever in Armed Forces?	If Yes, spe	dent of Hispanic Origin? (s cify Cuban, Mexican, Puer		14. Race - Amer White, etc.	ican Indian, Black,
fter de:			1 Yes 2 N	1 Yes	2 No specify:		Specify:	Black
hours a	ed by	15. Decedent's Education (Specif		d) 16a. Decedent's Usu	al Occupation (Give kind of vorking life. DO NOT use re	f work done	16b. Kind of Business/	Industry
36 hin 72 e than "	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+) na	i i	udent	,,,,,,	Schoo)1
5-00 led wit Hygien other		17. Father's Name (First, Middle, L	ast)			ne (First, Middle, M	aiden Surname)	
21215-0036 ould be filed within 7 Mental Hygiene, marked other than c event, the Medica	o Be	Darnell Brown 19a. Informant's Name/Relationship		10h Mailing Addre	Tonya	Randall	0	7.0
O # 5	L C	19a. Informant's Name/Relationship Tonya Randall	-Alexander	4215 Et	ss (Street and Number or hland Ave,	Baltim	ore, Md	21207
ore, Miss I and 2 sof Health a If item 27		20a Method of Disposition 1 X Burial 2 Cremation		Ob. Place of Disposition (Notice of Dispositi	ame of cemetery, ce)	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I and Department of Heal Important: If iten		4 Donation 5 Other Sper	cify:	King Memor		/9/06	Randalls	stown, Md
Bal permi Depar Impo	- 1	21. Signature of Funeral Service Li	censee	March	Maddress of Facility F/H West Wabash Ave	. Balti	more, Md	21215
Physician		22 Part . Enter the disease, or confailure. List only one cause or	om licalians that caused the de	eath. Do not enter the mod	e of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease or condition resulting in death)	a. Gunshot Wound to C					Death
		Sequentially list conditions,	Due to (or as a consequence b	ce on):				
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence.	ce of):				
18 g 2	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	ce of);				
760, cate be executed physician and he burial - transit	Medical	UNPENDED	dAMENDED					
760, icate be expension the burial		IF FEMALE: 23b Was decedent pregnant in the	23c. If yes, outcome of p	pregnancy			23d. Date of delivery	,
Box 687 death certifither attending and for use as t	ician	past 12 months?	1 Live birth 4 Pregnant at time of	2 Fetal death 5 Other (S)		nancy	Month [Day Year
. Bo) he death y the att	Physician	1 Yes 2 No 9 Unkno	9 Unknown			Loo Bitti		
P.O. E es that the digned by the ce detached	þ	Part II. Other significant condition	is contributing to death but no	ot resulting in the underly!	ng cause given in Part I.		acco use contribute to 2 ✓ No 3 Prob	
cords, Plaw requires that be seen sign 2 should be considered.	Completed					24a. Was ar autops		topsy findings available
tal Reco	omo				4	perform	ned? death?	completion of cause of
cian: certific	Be C	25. Was case referred to medical examiner?	Hospital: 1 Innationt 2		26 Place of Death (Check	only one)		
of Vi ing Physi After this uneral dir	리	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	✓ ER/Outpatient 3 28b. Time of Injury	DOA Other Nursi 28c. Injury at Work?		esidence 6 Other	:
Division of Vital Records, pital or Attending Physician: The law require ours after death erral birector: After this certificate has been siffled in by the funeral director, page 2 should be	Certification:	1 Natural 5 Pendin 2 Accident Investig	g Sep 6, 2006	0123 hrs	1 Yes 2 V No	Subject shot	,,	
lor At after d Direct d in by	tific	3 Suicide 6 Could	not be 28e. Place of Injury - A	At home, farm, street, facto	ry, office building, etc.	28f. Location (Stror Town, Sta		ral Route Number, City
Lospita 4 hours uneral		4 Homicide determ	ined (Specify) Local St sician: To the best of my know	-	he time, date and place, on		lace, Baltimore, N	
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certifuvithin 24 hours after death To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as the control of the control of the detached for use as the control of the control o	Medical	(Check only	ner: On the basis of examination and manner stated					
H 2 H 3	ž	29b. Signature and title of certifier	11200	2	9c. License number		29d. Date signed (Mor	
		30. Name and address of across	talle	tom 220)	O.C.M.E.		September 6, 20	06
3		 Name and address of person with Carol Allan, MD Assis 	no completed cause of death (It stant Medical Examiner	,	, Baltimore, MD 2120	01		
St	ate	31. Date filed (Month, Day, Year)	2006 32. Registrar's Sign	nature /	,			
Regist	(Eli	JEP V O	The state of the s					

State of Maryland / Department of Health and Mental Hygien 2006 28411 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Bisho 4a. Facility Name (If not institution, give street and number) 3 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Brodwas NIA N. BA ITO 1520 If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 □ F 259-22-0356 Director 10 1924 GIA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23a or 28e-1 show 1 res 2 □ No by Funeral Director M.D. BATTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 1520 U.S.A 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: BlAck 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry DRY DOCK. Elementary/Secondary (0-12) College (1-4or 5+) PAINTER 10grade None and Mental Hygin or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other treumatic event 9DCB. Bisho ၉ RKins 19a. Informant's Name/Relationship (Typ., Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christian 20b. Place of Disposition (Name of cemetery, crematory or other place) Berth 20a. Method of Disposition 1 Surial 2 □ Cremation 3 Removal from State Hill Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
BETTS FLORENT
1124 N. CAROL. ne 21. Signature of Funeral Service Licensee Patricia Bett 57 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition)

Atherosclerofic Cardio vasula, Discretified (death) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 10 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Completed by Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy signed by the atte Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown peeu : 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? certificate 1 ☐ Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner?

1 ☐ Yes ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Inpatient 2 ER/Outpatient 3□ DOA the Funeral Director: After this appletely filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave Baltimory MD 21224 Eastern Vissing mb 3509 32. gistrar's Signature 31. Date filed (Month, Day, Year) State SEP 08 Registrar 2006

Pleas	e Type or Pr						-		-	
For State	State of N	Maryland					Mental Hy	giene	2006	28412
Registrar			Cel	Tillicate	of Death	7	1	Reg. No).	
1. Decedent's Name (First, Middle, MYER 5	Last)	BRO	UNE				2. Date of De Month	Da		3. Time of Death
	7.					-4 D4b	SOTANBE		/	0-11
4a. Facility Name (If not institution, s 17 Brookings Co		ar)		,	wn, or Location N/A	of Death		40	. County of Dea Bala	timore
	5. Sex 7	Age (In yrs. las	t birthday)	If Under 1 Y		r 24 Hrs.	8. Date of Bir	th Voar	9. Bir	thplace (State or Foreign
386-14-2821 Usual Residence of Decedent	1 X M 2□ F	84	Yrs.	Months D	ays Hours	Min.	March 1	y, 194)	922 Teni	ressee
10a. State 10b. County		10c. City, 7	Town or Lo	cation						10d. Inside City Limits
Maryland Ba	ltimore			N/A						1 □Yes 2人No
10e. Street and Number				10f. Zip Co	ode			10g. Cit	izen of What Co	ountry?
17 Brookings Ct.					21234				u.s.	
11. Marital Status	12. Was Decede Armed Force		13.	Was Deceden 1 Yes, specify	t of Hispanic O Cuban, Mexica	rigin? (Sp an, Puerto	ecity Yes or No Rican, etc.))-	 Race - Ame Black, White 	
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	d 1 [V] Yes 2 [If Yes, Give Year or Date:			1□Yes 2💢					Caraller	rite
15. Decedent's (Specify only highest	Education grade completed)	1	(Give	dent's Usual C	don <i>e during</i> mo	st of work	ing	16b. K	ind of Business	/Industry
Elementary/Secondary (0-12)	College (1-40 5+	or 5+)		on Den	,	t Rec	reation	v.	A. Hoz	spital
17. Father's Name (First, Middle, La	ist)	1		0 -7			e (First, Middle,			
Charles Austin	Browne					Earl	ena But	tran	n	
19a. Informant's Name/Relationship	o (Type, Print)		19b. Mailir	ng Address (S	treet and Numb	ber or Run	al Route Numbe	er, City o	r Town, State,	Zip Code)
Virginia Dimeno	(Friend)		17 B	ooking	s Ct.	Balt	imore,	Mari	iland 21	234
20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name natory or othe	of				ocation - City or	
1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				raiory or oine Cremato		09/0	8/2006	Bal	timore.	Maryland
21. Smature of Funtal Service Lie	1	2009					imunek			
Somai	10 -		97	05 Bel	air Roc	ad, B	anuner Saltimor	runi	larylano	i 21236
28a. Part1. Enter the disease, or co	on plications that caus	ed the death.	Do not ent	er the mode o	I dying, such a	s cardiac	or respiratory ai	rrest,		Approximate
shock, or heart lailure. List or Immediate Cause (Final	ny one cause on each	i line.								Interval Between Onset and Death
disease or condition resulting in death)	a. CARC	INOMA		DF L	ung					3 MONTHS
Todaking in addition	Due to (or a	as a consequer	nce of):							
Sequentially list conditions,	b									
if any, leading to immediate cause. Enter Underlying	Due to (or a	as a consequen	ica of):							
Cause (Disease or injury that initiated events	c									
resulting in death) Last	Due to (or a	as a consequer	nce of):							
	a									
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon	ne of pregnancy	y _						23d. Date of del	iverv
in the past 12 months?		2 Fetal de at time of deat		Ectopic pregr Other (specif					Month	Day Year
1 Yes 2 No 9 Unknown	9□ Unknown			J Calor (Spoon	<i></i>					
Part II. Other significant condition:	s contributing to death	but not resultin	ng in the w	deriving caus	e gwen in Part	1	23e Did to	nhacco i	ise contribute to	the cause of death?
.4.		inc	كالكا	ME -	o givoir irr air			Yes 2		robably 4 Unknown
<u> </u>										
					-			rmed?	prior to death?	topsy findings available completion of cause of
25. Was case referred to medical							1 □ Yes	2 No	1 ∐ Yes	2 No
examiner?	Hospital:		10		0		h Check only o			
1 Yes 2 No	1 🗀 Inpa	itient 2 ER			401		me 5 Resid			cify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat		Day Year)	Bb. Time of Injury	28c. M	Injury at Work? 1 Yes 2		28d. Describe I	now injui	y occurred	
3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of	Injury - At home etc. (Specify)	a, larm, str	eet, factory, of	fice	2016-211. F	28f. Location (S	Street an	d Number or Ru	ıral Route Number,
4 Homicide determine	building,	etc. (Specify)					City or Tov	vn, State)	

within 24 hours after death.

To the Funerel Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, if a Medical Example insufficial at once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

1 Paritying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the daesu(s) and mainter as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

17

State

Registrar

MININSOFF Micha J. MI, 31. Date filed (Month, Day, Year)

32. Registrar's Signature

mo mpleted cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

		1 - For State Registrar	State of M	larylaı		artmer rtificat			and M		giene Reg. No.	006	2841
Physiciar /Medica Examine	ıl	1. Decedent's Name (First, Middle, Las BRUCE LEIGH 4a. Fecility Name (If not institution, give Saint Joseph	TON BYER)	ter	4b. Cily,	Town, or	Location o		2. Date of De Month BEFTEM	BER 7	Year	16 7:00 A
Funeral Director		5. Social Security Number 6. Social Security Number 7. Social Security Number 8. Social Security Number 9. Social Security	ex 7. A		. last birthday) Yrs.	If Under Months		If Under a	24 Hrs.	8. Date of Bir November	th 20,194	9. Bi	timore httplace (State or Fore cryffand
he Maryland 8a-f show	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimor	re		ity, Town or Lo	lle							10d. Inside City Lim 1 ☐ Yes 🌂 💢
23s or 2	מו חוב	13204 Falls Road				10f. Zip	2103	0			10g. Citizen	of What C	Country?
within 72 hours after death with the Maryland ene. Item "naturel", or items 23s or 28s-f show is Medicul Examiner must be notified at	a by rune	11. Marital Status Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces XXYes 2 ☐ If Yes, Give Year or Dates	? No		Was Dece If Yes, spe 1 Yes		spanic Orion, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		Race - Am Black, Wh ecify:	encan Indian, ite, etc. White
d 2 should be filed within 72 hours aft th and Mental Hygiens 27 is marked other then "naturel", or traumatic event, if a Medicul Exami	Completed by Funeral Director	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12		5+)		dent's Usu kind of wo DO NOT u NEMP 1	rk done d se retired	ation <i>luring</i> most)	of worki	ng	16b. Kind o	N/A	s/Industry
should be filed and Mental Hygia marked other umatic event,	lope	17. Father's Name (First, Middle, Last) George Byers								d Larmo		mame)	
and 2 sho lealth and N m 27 le ma her trauma		19a. Informant's Name/Relationship (7 David Albright	ype, Print) Cousi		4013	High	fiel		rt H	ampstea	id Mary	y l a nd	21074
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Example 1. It is marked other then "naturel", or items 23s or 28s-f show eny injury or other traumatic event, if a Medical Examinar must be notified at once.		20a. Method of Disposition XIX Burial 2 Cremation 3 Donation 5 Other (Specify 21 S nature of Funeral Service Licen)	, '	Place of Dispondential Complete United	natory or o I Met h	ch Ce d Addres	m !!	9/9/ Mitc	oate 06 hell-Wie Baltimon	Cockey lefedl 1	ysvil Tunera	rTown, State le Marylan I Home Inc 1212
The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate and the death certificated by Physician Medical Examines	icai cyanille	23a. Part1. Enter the disease, or composition, or heart failure. List only of the second state of the second state of the second	a. ADRTIC Due to (or as c. Due to (or as d. Due to (or as	RU s a consec DI s a consec	FTURE quence of): SSECT:		e of dying	g, such as o	cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death 7 HOURS
nat the death certificate be dby the attending physicle letached for use as the bur buxerial Medical	ysicialitime	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	al death 3	Ectopic pr Other (sp					23d.	Date of de Month	! blivery Day Year
quires that on signed by uld be deta	בֿ	Part II. Other significant conditions co	ontributing to death b	out not res	sulting in the u	nderlying c	ause give	n in Part I.			obacco use o		o the cause of death?
										24a. Was autop perfo 1 Yes		tb. Were a prior to death?	utopsy findings availat completion of cause o
is after death. Is after death. al Director: After this certificated in by the funeral director, p.	2	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpati 28a. Date of Inju (Month, Da	Jry	ER/Outpatien 28b. Time of Injury		8c. Injury Work	r: 4□Nur	sing Hor	Check only one 5 Residence 1986. Describe h	dence 6 🗆		ecify)
To the Hospital or Attenwithin 24 hours after deall To the Funeral Director: completely filled in by the		4 Homicide determined	building, et	tc. (Speci	ty) 					City or Tov	vn, State)		lural Route Number,
To the Hospital or within 24 hours after To the Funeral Direction of completely filled in the Madical Cert	מחוכם	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	rsician: To the best iner: On the basis of and manner st	of examina	owledge, death ation and/or inv	occurred restigation	at the tim in my op	e, date and inion, deat	i piace, a h occurre	and due to the ed at the time,	cause(s) and date and pla	manner a	s stated. e to the cause(s)
To the Yeithin 2 To the Complete		29b. Signature and title of certifier	1	us		E	License	number					th, Day, Year)
State Registrar		31. Date filed (Month, Day, Year)	INNEY M. 32. Registr	D. 7	7601 C			IVE -	TOWS	ON MA	RYLAN	ID 21	204

DHMH 17 Rev 1/2001

ORIGINAL

	an cal	Decedent's Name (First, Middle, Last) ANDREW PAUL	BINGAMAN			2. Date of Deat Month Septembe	Day Year	3. Time of Death 1:45P M
Examir		4a. Facility Name (If not institution, give street and Johns Hopkins Hospital	number)	4b. City, Town, or L Baltimor			4c. County of Dea	ath
Funeral Director		5. Social Security Number 186-38-7320 Usual Residence of Decedent	7. Age (In yrs. last birthday,	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 4,19	year) 9. 8i Per	rthplace <i>(State or Foreign</i> ountry) NNS ylvania
e Maryland Re-f ehow	Director	10a. State 10b. County Virginia Loudon	10c. City, Town or L	ocation				10d, Inside City Limits
with th a or 26 be no		10e. Street and Number		10f. Zip Code		11	0g. Citizen of What C	ountry?
filed within 72 hours after death with the Maryland Hygiene. Hygiene. Ifter then "natural", or iteme 23a or 28e-f ehow ont, the Marical Examinal miss be notified at	d by Funeral	1 Never Married XX Married 1 Yes, 3 Widowed 4 Divorced Year o	Forces? Is 300 No Give r Dates:	,,,,	Mexican, Puerto I Specify:	Rican, etc.)		white
be filed within 72 stal Hygiene. Id other than "nate event, the Mudicial stalls."	Completed		(Give life.	edent's Usual Occupati e kind of work done du DO NOT use retired) gent	ring most of workir	For Formula (,
be de la la la la la la la la la la la la la	To Be	17. Father's Name (First, Middle, Last) Paul Rearick	Bingaman	1	8. Mother's Name Barbara	•	Maiden Surname)	
and 2 should saith and Mer n 27 is marke ier traumatic		19a. Informant's Name/Relationship (Type, Print) Michelle Gallichio Bingaman		ing Address (Street an Chartered Cr				
it it		20a. Wathod of Disposition 1/MBurial 2 Cremation 3 Removal fro 4 Donation 5 Other (Specify)		osition (Name of ematory or other place)	1		20c. Location - City of State College	Town, State e, Pennsylvania
boparmit. Page My Medical Important: if Impo	ner	Sequentially list conditions b.	Kenderes	nter the mode of dying,	500 YORK R such as cardiac of	oad Baltir	more, Maryla	I Home Inc. nd 21212 Approximate Interval Between Onset and Death 6 months 2 years
ohysician and the burlal-transit	Medical Examine	resulting in death) Last Due 1 d. IF FEMALE: 23b. Was decedent pregnant 23c. If yes, 6		□Ectopic pregnancy			23d. Date of de Month	
	hysician/I	In the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Uni	known	Other (specify)				livery Day Year
	sted by Physician/Me	in the past 12 months?	known death but not resulting in the u		in Part I.		acco use contribute to s 2 X No 3 □ P	Day Year
	Completed by	in the past 12 months? 1	known death but not resulting in the u	underlying cause given		1 ☐ Yes 24a. Was ar autopsy perform 1 X Yes 2	24b. Were a prior to death?	Day Year of the cause of death? robably 4 Unknown utopsy findings available completion of cause of
sing Physician : The law requires that the death certifing. After this certificate has been signed by the attending to tuneral director, page 2 should be detached for use as	To Be Completed by	in the past 12 months? 1	Anown I're Inpatient 2 ER/Outpatier te of Injury onth, Day Year)	anderlying cause given 2 ant 3 DOA Other. 3 28c. Injury a Work? M 1 Ye	6. Place of Death 4 \(\text{Nursing Hom} \) t \(2 \) s \(2 \) \(\text{No} \)	1 Yes 24a. Was ar autopsy perform 1 Yes 2 Check only one ne 5 Resider 8d. Describe hor	24b. Were a prior to death? 1 Yes	Day Year o the cause of death? robably 4 Unknown utopsy findings available completion of cause of security)
sing Physician : The law requires that the death certifing. 1. After this certificate has been signed by the atlending t funeral director, page 2 should be delached for use as	Certification: To Be Completed by	in the past 12 months? 1	Anown I're Inpatient 2 ER/Outpatier te of Injury onth, Day Year) Ice of Injury - At home, farm, strilding, etc. (Specify)	anderlying cause given 2 nt 3 DOA Other. of 28c. Injury a Work? M 1 Ye reet, factory, office	16. Place of Death 4 \(\text{Nursing Hom} \) t \(2 \) s \(2 \) \(\text{No} \)	1 Ye. 24a. Was ar autopsy perform 1 X Yes 2 Check only one 18 5 Resident St. Describe horology of the City or Town,	24b. Were a prior to death? No 3 P	Day Year o the cause of death? robably 4 Unknown utopsy findings available completion of cause of security)
Physician: The law requires that the death certific this certificate has been signed by the attending frid director, page 2 should be detached for use as	To Be Completed by	in the past 12 months? 1	Anown I're Inpatient 2 ER/Outpatier te of Injury onth, Day Year) Ice of Injury - At home, farm, strilding, etc. (Specify)	anderlying cause given 2 nt 3 DOA Other. of 28c. Injury a Work? M 1 Ye reet, factory, office	6. Place of Death 4 Nursing Hom t 2 s 2 No 2	1 Ye. 24a. Was an autopsy perform 1 X Yes 2 Check only one 18 5 Resider 18 8d. Describe how 18 18 18 18 18 18 18 18 18 18 18 18 18 1	24b. Were a prior to death? No 3 P	Day Year of the cause of death? robably 4 Unknown utopsy findings available completion of cause of secify) ural Route Number, enterty of the cause(s)

		State of Marylar	od / Department of				001.15
41.	1 - State Registrar	•	Certificate of	f Death	Reg. No.	.006	28415
Physician	1. Decedent's Name (First, Middle, La	-		2	2. Date of Death Month Day	Year	3. Time of Death
/Medical Examiner	4. Facility Name (If not institution air	ph E. Bauer	4b. City, Town,	or Location of Death		23,200 County of Death	100
LXamilier	Sinai Hospi	tell of Bal	timor Bal	timore	CIH		
Funeral Director	5. Social Security Number 6. S 219-16-8538		last birthday) If Under 1 Yea Months Days	s Hours Min.	B. Date of Birth (Month, Day, Year) 9/13/24	9. Birthplac Country, Maryl	
g	Usual Residence of Decedent	100 6	Town or Leasting		2/13/24		, Inside City Limits
Aarylar I show	10a. State 10b. County MD Baltim		ckeysville			100.	1 □ Yes ¾∰No
036 ours after death with the Maryland rai; or iteme 23e or 28e-1 show Examiner must be recitified at the Funeral Director	10e. Street and Number	.020	10f. Zip Code		10g. Citiz	zen of What Country	?
ath witi				21030		USA	1 - 2 -
	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? ₩₹₩es 2 □ No	.S. 13. Was Decedent of If Yes, specify Cu	f Hispanic Origin? (Specuban, Mexican, Puerto R	ify Yes or No-	4. Race - American Black, White, etc	
5-0036 72 hours after natural, or its	3€ Vidowed 4 □ Divorced	to the second of the second o	1 ☐ Yes 🌿 💆 N	o Specify:		Specify: Whi	te
21215-003 21215-003 39 on within 72 hours ygione. The modical Examples and the modical Examples	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Decedent's Usual Occ (Give kind of work don	upation ne during most of working red)	16b. Kir	nd of Business/Indus	stry
d 2121 d 2121 hygiene.	Elementary/Secondary (0-12)	College (1-4or 5+)	Preside			S Tile C	ompany
nd 2 be filed tal Hygin of other	17. Father's Name (First, Middle, Last				First, Middle, Maiden		
Maryland 212: Maryland 212: Maryland 212: T is marked other than T Be Comp	19a, Informant's Name/Relationship (WARD KAL	19b. Mailing Address (Street		ne Bergei		ode)
Ma Ma	Steven E. B	** '	19002 Hunt			n, MD 21	
Baltimore, N Baltimore, N Bernit. Pages 1 and Department of Health Important: If tiem 27 Inty injury or other tr pages.	20a. Method of Disposition 1 Strain 2 ☐ Cremation 3 ☐		Place of Disposition (Name of cemetery, crematory or other p		te 20c. Loc	cation - City or Town	
Baltimol Basiment Pages Department of Important: If I is any injury or o	4 Donation 5 Other (Special Service Lice	y) Pa:	rkwood Cemet			kville, Harford	
Bal Bal Department of the sand in the sand	21. Signature of Funeral Service Lice			meral Cha	Tin soler	ville, M	
W- WIN	23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the dea				A	approximate nterval Between
Physician	Immediate Cause (Final disease or condition resulting in death)	. A cute	Myocardi	al Inf	ferction.		Inset and Death
/Medical Examiner	resulting in deality	Due to (or as a conse	,	ai lur.	e		
3	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as conse	quence of):	11.00			
Company of the second of the s	Cause (Disease or injury that initiated events resulting in death) Last	c. Lntev Due to (or as a conse	evebral	H MO	rr has-e		
price 66		d					
Records, P.O. Box 687 The law requires that the death certificate the has been signed by the attending physicage 2 should be detached for use as the							
S, P.O. Box 68 es that the death certifical gned by the attending phy be detached for use as the best of the second property of the secon	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of	al death 3 Ectopic pregnar		2	23d. Date of defivery Month Date	ay Year
the de ached	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	SEI OTHER (Specify)				
S, P	Part II. Other significant conditions			given in Part I.		se contribute to the	
Ord: require		rubrillati				□No 3 □ Probab	
II Record The law requir	Congestiv	e Heavi	failure		24a. Was an autopsy performed?	prior to comp death?	y findings available otetion of cause of
	25. Was case referred to medicat			26. Place of Death	(Check only one)	1 ☐ Yes ←	
of Vi	examiner?		JENOutpatient 3 DOA		e 5 Residence 6		
Division of Vital Records, ior Attending Physician: The law requires the death. Director: After this certificate has been signed in by the funeral director, page 2 should be considered.	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)		njury at 2 Vork? ☐ Yes 2 ☐ No	8d. Describe how injury	/ occurred	
Division c tal or Attending P rs after death. al Director: After t ed in by the tuners	2 Accident investigation 3 Suicide 6 Could not investigation 4 Homicide determined	De Die er et leius, Atl	nome, farm, street, factory, officially	ce 2	8f. Location (Street and City or Town, State		Poute Number,
Divinital or urs after rai Diri							
Hosp 24 hou Fune stely fil		hysician: To the best of my kr miner: On the basis of examin and manner stated.					
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	29b. Signature and title of certifier		29c. Lice	ense number	29d. Dat	e signed (Month, Da	ay. Year)
	1 Sylvan	repogremme	D	54931	Au	gust 8	13,2006
10+1	30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print) 5 (NA)	HUSPIT	AL OF	BALTIM	nors
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign			,, 0,	V 11.	

DHMH 17 Rev 1/2001

			For State	State of Maryland	d / Department of I			りりりと	28416
	Physici	an	Registrar 1. Decedent's Name (First, Middle, Las				Reg. No 2. Date of Death Month Da		3. Time of Death
	/Medic Examin	cal	MOUID 4a. Facility Name (If not institution, give	LISTON street, and number) , (OOUI	or Location of Death	Sept 5		334 pm
			Baltimore V. 5. Social Security Number 6. Se	4 Medical	enter Bal- ast birthday) If Under 1 Year	IMOVE		,	
	Funeral Director		249.36.9639	7. Age (In yrs. It	Yrs. Months Days	Hours Min.	B. Date of Birth (Month, Day, Year) 16 · 02 · 1920	9. Birthp Coun	elace (State or Foreign etry) 8C
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location			1	0d. Inside City Limits
	he Mar 28a-f sl	ector	MD NA	BALT	IMORE		· · · · · · · · · · · · · · · · · · ·		1 ☑ Yes 2 ☐ No
	h with	Funeral Director		ENUE	10f. Zip Code 212	11.	Tog. Cr	tizen of What Coun	ntry?
	r deat	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?			ify Yes or No-	14. Race - Americ Black, White,	
036	filed within 72 hours after death with the Maryland Hygiene other than "natural", or Itams 23a or 28a-f show ant, the Modical Exer unser, ust be notified at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 M2Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2018 No			Specify: BLAC	
15-0	"natur	leted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of working	16b. K	ind of Business/Ind	
212	filed within Hygiene. ther than int, Ine M	Completed	Fiementary/Secondary (0-12) 9	College (1-4or 5+)	STEEL WORKE		BE	IH. STEE	<u>iL</u>
Maryland 21215-0036	ed fa	To Be (17. Father's Name (First, Middle, Last) JAMES BOULE	'		18. Mother's Name	(First, Middle, Maider 山 ん)	Sumame)	
Aary	2 should and Men is marka raumatic	-	19a. Informant's Name/Relationship (7		19b. Mailing Address (Street	and Number or Rural	Route Number, City		Code)
	thealth tem 27 other tr		PERNETTA BOULE 20a. Method of Disposition		ace of Disposition (Name of	AVE. BALI		217 ocation - City or To	wn, State
imore,	Pages ment of I ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	nemoval from State	ometery, crematory or other pla LDON PARK	φ·φ.	Ob BALT	IMORE !	MD
Balti	permit. Page Department Important: If any injury of		21. Signature of Funeral Service Licent		22. Name and Addre VAUGHN C.	ASS OF FACILITY CAREENE FUN NATI PIKE	JERAL SERVI	Œ	
	1200		23a. Part1. Enter the disease, or composhock, or heart failure. List only of	lications that caused the death				21,724	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	nary Hy	lperte	ension	7	Onset and Death
	Examiner		Service timbe list one officers	Due to (or as a consequ	lence of):	*			
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	rence of):				
Ö,	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):				
68760	ficate be ex physician is the buria	edicai		d					
Вох	eath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnal		у		23d. Date of delive	•
o.	that the dealed by the all detached for	Physician/Me	1 Yes 2 No	4□Pregnant at time of de 9□Unknown	ath 5 ☐ Other (specify) _			Month	Day Year
S, D	uires that signed b d be deta	by	Part II. Other significant conditions co	entributing to death but not resu	alting in the underlying cause gr	ven in Part I.	_ \	use contribute to th	_
Record	w requir been si should	ompleted					1 Yes 2		
	The lavate has	Comp					24a. Was an autopsy performed?	prior to cor death?	psy findings available inpletion of cause of
Vital	lcian: Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:	0	26. Place of Death		1000-1	
	Phys r this sral dir	To To	1 Yes 2 He	28a. Date of Injury	ER/Outpatient 3☐ DOA 28c. Injui		e 5 Residence		/)
ion	Attending Physician: ir death. actor: After this certificaby the funeral director,	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury Wo	rk?]Yes 2□No	,-	,	
Division of	af or Attending is after death. I Diractor: After d in by the funer	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory, office	28	3f. Location (Street at City or Town, State	nd Number or Rura a)	l Route Number,
	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai C	29a. Certifier 1 Certifying Phy (Check only one)	vsician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, death occurred at the ti ion and/or investigation, in my o	me, date and place, ar opinion, death occurred	nd due to the cause(s d at the time, date an) and manner as st d place, and due to	ated. the cause(s)
ı	To the within To the	Me	29b. Signature and title of certifier	•	29c. Licens		. 1	te signed (Month,	
•			30. Name and address of person who of	omplet dicause of death (from	23a) (Type Briet)	1854	1 5	2P+ 5	, 2006
_	8		matther Nola, m	o IDW.	23a) (Type, Print) Leve St. ure	Baltin	ore, mo	212	01
	Sta Regista		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture				
DH	MH 17 Rev 1/2		SEP 0 8	LUUDI EMPERE	is fourth				*.*.

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2006 28417 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 05 0 **Physician** BUTLER 4:30 A M GEDRGE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Bon Secour Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Nonths Days Hours Min. 11/02/1947 Birthplace (State or Foreign Country) 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Yrs. Director 58 216-50-0875 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location rthan "natural", or Itama 23a or 28a-f ahow the Medical Examinar must be notified at Baltimore City 1 XYes 2 No n/a Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2581 W. Fayette Street 21223 IIS Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th masonry 1mknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 Is marked oth any ligury or other traumatic avant 2005. Warren Butler Alberta Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret B. Jenifer / Sister 250 New Castle Drive; Shillington, PA 19607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Mount Zion Cemetery 09/09/2006 Baltimore, MD (city) 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street; Baltimore, MD 21217 mes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BILATERAL **Physician** PNUEMONIA /Medical Due to (or as a consequence of): Examiner DESOPHAGEAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attanding Physician: The law requires thet the death certificate be executed attending physicien and for use as the burial-transit ARTERIOSCLEROTIC MEART DISEASE Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. RENAL DISEASE Physician/Medicai STAGE IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Monknown ANAEMIA Be Completed 24b. Were autopsy findings available prior to completion of cause of death? MALNUTRITION 24a. Was an SEVERE autopsy performed? 2 No 1 Yes 2 400 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 23300 SEPTEMBER 05 06 MD. BON SELCURS KUSP. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUDHIR. D. PATEL. MD. 2000W BALTO. ST. BALTO 31. Date filed (Month, Day, Year) 32 egistrar's Signature State Registrar

DHMH 17 Rev 1/2001

06-06613 Bonnie Cowger

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 28418

	1- For State Certification Cer	ficate of Death	Reg. No.	10 2041
Physician/ ledical Examiner	1. Decedent's Name (First, Middle, Last) Bonnie Rena Cowger		2. Date of Death Month Day Year September 4, 2006	3. Time of Death 0654 hrs
and the same of th	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	
	Johns Hopkins Bayview Medical Center	Baltimore		
Funeral Director	5. Social Security Number 220-64-4542 Usual Residence of Decedent	Yrs. H Under 1 Year If Under 24Hrs Months Days Hours Min.	03-23-1052 Fore	
any	10a. State 10b. County 10c. City, To	own or Location		10d. Inside City Limits
faryland 28a-f show any 1 at once. ector		ltimore		1 Yes 2 No
h the Maryland 3a or 28a-f sh otified at oned	10e. Street and Number 8030 Stratman Rd.	10f. Zip Code 21222	10g. Citizen of What Co USA	untry?
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes 2XX No specify:	Rican, etc.) White, etc.	rican Indian, Black, Ö
ours aft atural" camine	or Dates:	6a. Decedent's Usual Occupation (Give kind of v	vork done 16b. Kind of Business	
5-0036 ed within 72 ho tygiene other than "na the Medical Ex	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use reti Machine Operator	Stee1	
21215-0036 21215-0036 Juld be filed within 7 Mental Hygiene marked other than ite event, the Medica FO BE Comple	17. Father's Name (First, Middle, Last) Elis Martin Wood	Wani	(First, Middle, Maiden Surname) ta Marrs	
MD 21 nd 2 should ulth and Me m 27 is ma aumatic ev	19a Informant's Name/Relationship (Type, Print) William Cowger/husband	19b. Mailing Address (Street and Number or F 8030 Stratman Rd	. Baltimore MD	21222
Baltimore, vernit Pages Lan Department of Hea Important: If Hea njury or other tr.	1 Rurial 2 XX Cremation 3 Removal from State Cre	ce of Disposition (Name of cemetery, matory or other place) sapeake Crematory		
Balt permit Departi Impor	2) Signature of Funeral Service Licensee Type Retter M01443	22. Name and Address of Facility CA 8717 Green Past	ures Dr. Baltin	21286 more MD
Physician /Medical	23a. Part Enter the disease, or complications that caused the death. D failure. List only one cause on each line.	o not enter the mode of dying, such as cardiac of ardiovascular disease	r respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
Examiner	or condition resulting in death) Due to (or as a consequence of):	ardiovascular disease		1 -
ed nsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			
d ansit	events resulting in death) Last Due to (or as a consequence of): d.			
760, frate be executed physician and the burial - transit	X UNPENDED AMENDED item#23a.P	II,27,perME,g859,9/20/06 TT		
8760, ifficate be expansion of physician is the burial of m/Medic	IF FEMALE: 23b. Was decedent pregnant in the	ncy 2 Fetal death 3 Ectopic pregna	23d. Date of delive	ry Day Year
. Box 68760, the death certificate by the attending physic ched for use as the bur Physician/Mec	past 12 months? 4 Pregnant at time of death 9 Unknown			
P.O. E es that the d igned by the detached by the d tag by the d by the d by the d by the d by by	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	-
S, P puires ti nu signe ald be d	Fatty liver		1 Yes 2 No 3 Pro	
Records, The law requires ficate has been sig page 2 should be Completed				autopsy findings available completion of cause of
tal Rection: The Corrigions page	25. Was case referred to medical	26 Place of Death (Check of	1 Yes 2 No 1 Y	
Vital I ysician: his certifi director, o Be (examiner?	- Other -	g Home 5 Residence 6 Othe	er:
Division of Vital Records, rat or Attending Physician: The law require ra after death. al Director: After this certificate has been si led in by the funeral director, page 2 should be rtification: To Be Completed	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	8b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
Sion Attend r death. ector: by the i	2 Accident Investigation	1 Yes 2 No		
Division o spiral or Attending nours after death. neral Director: Afte filled in by the fune Certification:	3 Suicide 6 Could not be determined (Specify)	e, farm, street, factory, office building, etc.	28f. Location (Street and Number or R or Town, State)	tural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transledical Certification: To Be Completed by Physician/Medical E.	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and			
Me S. T. S. T.	29b. Signature and title of certifier	29c. License number	29d. Date signed (M	onth, Day, Year)
	highi, mo	O.C.M.E.	September 5, 2	006
10.0	 Name and address of person who completed cause of death (Item 23 Ling Li, MD Assistant Medical Examiner 111 P 	^{Ba)} enn Street, Baltimore, MD 21201		
State	31. Date filed (Month, Day, Year) 32. Redistrar's Signature SEP 0 8 2006	Land 2		

ORIGINAL

06-06477 Cailey E. Clark

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

ancy E. Olan	F	- For State Control of Certificate o	f Death	Reg. No.	006 2841						
Physicia	ın/	1. Decedent's Name (First, Middle,Last) Kailey Elizabeth Clark		Date of Death Month Day Year	3. Time of Death 0633 hrs						
∕ledical Examiı ,—≺,			4b. City, Town, or Location of Death	August 29, 2006							
		Franklin Square Hospital	Rosedale	Baltimore							
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min.	B. Date of Birth(MM/DD/YYYY)	Foreign						
Director		218-75-5923 1 M 2XF 0 Yrs	2 8	06/22/2006	Country Maryland						
any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locat	ion		10d. Inside City Limits						
*	_	Maryland Baltimore Es	sex		1 Yes 2 X No						
daryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of Wh							
th the Maryland 23a or 28a-f sho notified at once.		1300 Sugarwood Circle, Apt. 301	21221	u.s.							
ath wif	Funeral	1 X Never Married 2 Married Armed Forces?	as Decedent of Hispanic Origin? (Speci es, specify Cuban, Mexican, Puerto Ric		- American Indian, Black, , etc.						
fiter de I", or i		1 Yes 2 X No 3 Widowed 4 Divorced of Pales:	Yes 2 X No specify:	Specify:	White						
ours a	g b	15. Decedent's Education (Specify only highest grade completed) 16a. Deceder during m	nt's Usual Occupation (Give kind of work nost of working life. DO NOT use retired)		siness/Industry						
36 in 72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Infant	N/A							
5-0036 led within 7/ tygiene. other than the Medical	ĕ	17. Father's Name (First, Middle, Last)		irst, Middle, Maiden Surname)							
21215-0036 hald be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Ronald C. Clark	Lauren								
	٩		g Address (Street and Number or Rural) Sugarwood Circle,								
Baltimore, MD oemit Pages I and 2 she Department of Health and mportant: If item 27 is njury or other traumati	- 1	20a. Method of Disposition 20b. Place of Dispo	sition (Name of cemetery, D	· · ·	City or Town, State						
nore		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: Holly Hill	ther place) El Mem'l Gard 9/2,	/2006 Baltimo	re. Maryland						
Baltimore permit Pages I Department of I Important: If injury or other	ı	21. Signature of Funeral Service Licensee 22.1	Name and Address of Facility Schu	munek Funeral	Homes						
		tall the	9705 Belair Rd., Bo	altimore, MD 2	21236						
Physician /Medical		failure. List only one cause on each line.									
Examiner		Immediate Cause (Final disease or condition resulting in death) a Sudden unex lained death Due to (or as a consequence of):	пі ппаку								
		Sequentially list conditions, b.									
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated									
√ ed √	Examiner	events resulting in death) Last Due to (or as a consequence of): d.									
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Medical	fr]	erMEG861,11/2/2006 TT								
760, icate be physicate buri	Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of	delivery						
687 certifi inding ise as t	sician	past 12 months?	etal death 3 Ectopic pregnancy	y Month	Day Year						
Box death the atte	ysi	1 Yes 2 No 9 Unknown 9 Unknown	ther (opeany)								
bat the ed by tetache	by Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		bute to the cause of death? Probably 4 Unknown						
S, P puires t	ed				Vere autopsy findings available						
cord law red has be 2 shou	ompleted		· · · · · · · · · · · · · · · · · · ·	autopsy p	prior to completion of cause of leath?						
Rec The ficate	ပ္ပြ	25. Was case referred to medical	26 Place of Death (Check onl		Yes 2 No						
/ital sician sicerti	o Be	examiner? Hospital: 1 Inpatient 2 PR/Outpatier	IOther		Other:						
of Vital Records, P.O. Box 68: ing Physician: The law requires that the death certificate has been signed by the attending funeral director, page 2 should be detached for use as it.		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of	Injury 28c. Injury at Work? 28	3d. Describe how injury occurr	ed						
ion rtendir death rtor: A	atio	Natural 5 Pending Pending Prod 8/29/2006 FNd 4:4		unknown							
Division of Vital Records, P.O. Box 68 tall or Attending Physician: The law requires that the death certif and Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, str	eet, factory, office building, etc.	Bf. Location (Street and Numb FOT ESSEX, MDO S	er or Rural Route Number, City Sugarwood Circle,						
Cospita Hours Unera		29a. Certifier									
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death To the Functal Director: After this certificate I completely filled in by the funeral director, page	Medical	(Check only one) 2 ✓ Medical Examiner: On the basis of examination and/or investig and manner stated.									
T wi	Me	29b. Signature and title of certifier	29c, License number		ed (Month, Day, Year)						
		hij hu, miss	O.C.M.E.	August 30,	2006						
0/		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Stre	eet, Baltimore, MD 21201								
	tate		Coarles								
Regis		or or or broken to									

December of the control of the contr				For State Registrar	State of Maryla	and / Dep <i>Ce</i>	artment of Hertificate of I	lealth and l Death	Mental Hygie	2006	28420
Third color of the		Physici	20)	<i>a</i> 1 1	C		2. Date of Death	_	
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Social Social		Examin	ier						*1		
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Security Security	320	irs afte	by Fu		If Yes, Give		1 ☐ Yes 2 💢 No	Specify:		Specify:	White
Security Security	2-0	72 hou nature				16a. Deci	edent's Usual Occup	ation	rkina 16	b. Kind of Business	/Industry
19. Hard Name (Pred. Modes, Last) George J. Exhault 19. Internative Name Predictions (19.00) 19. Internative Na	7	within ane. then	mple	Elementary/Secondary (0-12)						Medical	
Part 19 19 19 19 19 19 19 1	Z	filed v Hygie other I	0			meace	100 1001001		me (First, Middle, Ma		
198. Maring Address (Sines and Number of Part Route Number, City or Town, State, 25 cost) 199. Informative NamePathaloconthin (Type, Profit) 200. Maring Address (Sines and Number, City or Town, State) 201. Place of Deposition, Them or State of Part of	Van	Mental Mental mrked	To B	George J. Erho	rdt			Cather	cine Sy	lvious	
20. Date of Disposition (Allema of Disposition) (Allem		12 sho h and 7 ts mu treum								-	Zip Code)
1 Sural 2 Complaint 2 Comp	ရ. -	- 2 5 5		20a. Method of Disposition	20						Town, State
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And any leaded to immediate cause. Enter Underlying cause given in Part I. PENDOD NATION Part II. District Distr				Toolaning in dodain,			MET	ASTA	-513		2006
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Temporary Company Co		end end I-trans	xam	that initiated events	c	sequence of):					
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9 Unknown 9 Unkn	ô n	eath ce	clan/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 P	etal death 3					
24a. Was an autopsy findings available prior to completion of cause of death? 25. Was case referred to medical examiner? 1 Yes 2 No 3 Probably 4 Unknown autopsy findings available prior to completion of cause of death? 25. Was case referred to medical examiner? 1 Yes 2 No 3 Probably 4 Unknown autopsy findings available prior to completion of cause of death? 26. Place of Death (Check only one) 27. Manner of Death 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 6 Residence 6 Other (Specify) 28a. Date of Injury At home of Injury At home of the cause of death 1 Yes 2 No 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Da	j.	y the	hysi								
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Second S	ဝ္	law rec as bee 2 shou	plete							24b. Were a	utopsy findings available
27. Manner of Death Natural S Pending investigation	ľ	The ate his page	Com						performe	d? death?	
27. Manner of Death Natural S Pending investigation	V [5	sician certific irector	00	examiner?	Hospital:	Q 50/0	Oth	ac .		. Fo: 10	
29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who comprehence of death (Item 23a) (Type, Print) 22d. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who comprehence of death (Item 23a) (Type, Print) 22d. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 27d. Check only 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	ō	g Phy er this eral d		27. Manner of Death	28a. Date of Injury	28b. Time	ALL SEL DOM	4 Li Nursing r			icity)
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				31. Date filed (Month, Day, Year)	32. Registrar's Si	ignature					

			1 - For State Registrar	State of Maryland		of Health and of Death		ene 2006	28421
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physici /Medic		Julia A. (onaway			Month	Day Year	5:30 AM
	Examin		4a. Facility Name (If not institution, give st		4b. City, 1	own, or Location of Deat	h	4c. County of Deat	
			March Care H	onth Service	os Tou	WSON		Pattine	Re
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		1 Year If Under 24 Hrs			hplace (State or Foreign untry)
п	Director		231-44-3784 10	W 281F 69	Yrs. Months	Days Hours Min.	(Month, Day,	1936	vA ✓A
	pu ,		Usual Residence of Decedent						
	aryla show	_	10a. State 10b. County		Town or Location				10d. Inside City Limits
	Ba-f	cto	MD NA	Bal	timore				1 ☑ Yes 2 ☐ No
	1 2 2 E	Director	10e. Street and Number	\	10f. Zip	Code	10	g. Citizen of What Co	untry?
	within 72 hours after death with the Maryland ene. than "neturel", or Itema 23e or 28e-f show the Medical Examinat notal be notified at		5801 Woodcrest	Ave.	915	115		JSA_	
	teme term	Funeral		Was Decedent Ever in U.S. Armed Forces?	13. Was Deced	ent of Hispanic Origin? (S fy Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
36	or I	by Fı	1 Never Married 2 Married	1 ☐ Yes 2 🔯 No If Yes, Give	1 ☐ Yes 2	⊠ No Specify:		Specify:	
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5	"nat	Completed	15. Decedent's Educa (Specify only highest grade	completed)	16a. Decedent's Usua (Give kind of work life. DO NOT use	k done during most of wo	rking 1	6b. Kind of Business/l	Industry
12	withir	ш	Elementary/Secondary (0-12)	College (1-4or 5+)		al r	1	201-11	
	filed Hygir ther ant,		17. Father's Name (First, Middle, Last)	N/A	sales A	Sistance 18. Mother's Na	me (First, Middle, M	laiden Sumame)	
an	d be antal	o Be	C. 1. 11 0 -	2017				Nashinato	.0
Maryland	2 should be filed withir and Mental Hygiene. is marked other then aumatic event, the Me	^T	19a. Informant's Name/Relationship (Type	<u> </u>	19b. Mailing Address	(Street and Number or Ri		V	
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ē,	- 주 등 등		20a. Method of Disposition	20b. Plac	ce of Disposition (Nam	e of		MD 2315 Oc. Location - City or	
altimore,	5 = 5 6		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	moval from State	netery, crematory or ot		. c.land I) v == 5.11	ALD
量	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Licenses	Dra				Kesville	MD
Ba	permi Depa Impo any ir		Moseph C	Greone	2000		Funeral	more Mi	21220
		-	23a. Part1. Enter the/disease, or complic shock, or heart failure. List only one						Approximate
			shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	1/5 11 1				Interval Between Onset and Death
	Pnysician /Medical	i i	disease or condition resulting in death)	CAKCII	VOTTA	9 0	06010		4483.
	Examiner			Due to (or as a conseque	nce or):	0			
		e	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	nce of):				
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ó	cate be executed oblysician and the burial-transit	Examiner	resulting in death) Last	Due to (or as a conseque	nce of):				
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9		ed	1.5%						
Вох	The law requires that the death certific ite has been signed by the attending it page 2 should be detached for use as	Physician/Me	230. Was decedent program	c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de		ananov.		23d. Date of deli	very
-	deat	ic is	in the past 12 months? 1 □ Yes 2 □ tho	4☐Pregnant at time of dea:				Month	Day Year
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	es tha igned be de	by F	Part II. Other significant conditions conti	ibuting to death but not resulti	ng in the underlying ca	use given in Part I.	23e. Did toba	acco use contribute to	1.7
ord	w require been si should t						1 🗆 Yes	s 2 No 3 Pro	obably 4 nknown
Records,	e taw re has be je 2 sho	plet					24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
Ä	The ate he page	Completed					perform	qd2 death?	2 No
Vital	ysiclan: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one		
of V		To	1 ☐ Yes 2 No	spital: 1 ☐ Inpatient 2 ☐ EF	NOutpatient 3 DO	Cther: 4 Nursing H	Home 5 ☐ Resider	nce 6 Other (Spec	cify)
			27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of 28	c. Injury at Work?	28d. Describe how	v injury occurred	
0	Attanding or death. actor: After by the fune	ati	2 Accident investigation		М	1 ☐ Yes 2 ☐ No			
Division	or Attand after death Diractor: /	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factory,	office	28f. Location (Stre City or Town,	eet and Number or Ru. State)	ral Route Number,
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	To the Hostiltal or Att within 24 hours after d To the Funeral Diract completely filled in by	edical	(Check only Z Medical Examine	cian: To the best of my knowledge: On the basis of examination	edge, death occurred a n and/or investigation,	t the time, date and place in my opinion, death occi	e, and due to the car urred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	thin 2 the mple	Med	29b. Signature and title of contings	and manner stated.		License number		d. Date signed (Month	
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	-040	to	31. Date filed (Month, Day, Year)	32. Redistrar's Signatur	0 10		C MEN		
	Sta Registr		SFP 0 8 20	32. Registrar's Signatur	S. Louis	,3			
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			For State of Maryland / Department of Health and I State of Registrer State of Maryland / Department of Health and I Certificate of Death		giene 00	6 28422
	D 1		1. Decedent's Name (First, Middle, Last)	2. Date of De Month		3. Time of Death
	Physicia /Medic		William E. Colliflower		er 3, 20	
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat		4c. County of	
			Greater Baltimore Medical Center Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs	9 D-14 Bi-	Baltimo	
	Funeral Director		1KIM 2DF Months Days Hours Min.		y, Year)	Birthplace (State or Foreign Country) PA
_			194-16-4295 81 Usual Residence of Decedent	9-10-	1924	r A
\geq	death with the Maryland ms 23a or 28a-f ehow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
\mathcal{A}	B Mar	ctor	MD Baltimore Lutherville			1 ☐ Yes 2 No
9	or 28	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of Wh	at Country?
	ath w	ral	114 Croftley Road 21093		USA	
		Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	Specify Yes or No to Rican, etc.)	- 14. Race - Black,	American Indian, White, etc.
≥ 98	rs aft	by F	1 □ Never Married ② Married 1 □ XYes 2 □ No WWII 1 If Yes, Give 1 □ Yes 2 ☑ No Specify: Year or Dates: \$. ¥ Or O 3		Specify:	White
, ~음	within 72 hours after ane. then "naturel", or ite in Medical Examine	edt	3 □ Widowed 4 □ Divorced Year or Dates: & Korea 15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Busin	wtsubul/see
15	n na	Completed	(Specify only highest grade completed) (Give kind of work done during most of work	rking	TOD. PURIO OF DUSIN	1853/110UStry
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الحرا	vild b Ments virked	ToE	Joseph M. Colliflower Clara	Nicho1		
Maryland	s 1 end 2 should be filed within I Health and Mental Hygiene. Item 27 ie marked other then other treumatic event, <u>tre M</u>		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Re			
	end ealth n 27 ner tr		Angela Colliflower - Wife 114 Croftley Rd.,		ville,	MD 21093
(CS)	ges 1 t of H if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	Date	20c. Location - Ci	ty or Town, State
E (Pag Iment Iury		4 □Donation 5 □Other (Specify) Dulaney Valley 9-16			ille, MD
Ball	permit. Pages 1 end : Depertment of Health Importent: if item 27 eny injury or other tr		21. Signature of Funeral Service Eicensee 22. Name and Address of Facility Bra	-		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	c or respiratory ar	rest,	Approximate Interval Between
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Вох	atter I for u	clar	in the past 12 months?		Month	
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rgs	quire in sig uid bi	D D	Pubolic strucke	101	(es 2 No 3)	Probably 4 Unknown
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	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	100		_
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06-06515

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene **UNK UNK** Certificate of Death 1- For State Rea. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month August 30, 2006 2254 hrs Canady Joyce Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore NA Johns Hopkins Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs last birthday) **Funeral** Foreign Country) Months Davs Hours Director 218-78-8887 М 2**X** F 39 08-31-1966 Md. Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location iny 10b. County 1 X Yes 2 No 28a-f show Baltimore or items 23a or 28a-f shov r must be notified at once. NA Md. Director nours after death with the Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21223 32 S. Fulton Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, 12 Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married Yes Black 3 Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify. Specify "natural". þ or Dates 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hou Department of Health and Mental Hygene Important: If item 27 is marked to Meeting wan injury or other treatment to the work. Elementary/Secondary (0-12) College (1-4 or 5+) 9th grade Nursing Assit. Ashburton N.H. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Smith Canady Rosie æ Lasalle 10 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 16 N. Streeper Street, Baltimore, Md. Rebecca White Sister 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 9-8-06 Dundalk, Md. Mt. Carmel Cem. 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure List only one cause on each line /Medical Death Alcohol and Narcotic intoxication and cocaine use Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed pue Physician/Medical rsician a X UNPENDED AMENDED item#23a,27,28a-f,perME,g860, 10/11/06 TT Division of Vital Records, P.O. Box 68760, attending physion use as the bu IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No page 1 🗸 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) To the Hospital or Attending Physician: Be Other Nursing Home 5 Residence 6 Other Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 DOA 1 🗸 Yes 2 No 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 5 Pending Director: Fnd 8/30/2006 Fnd 11:02 pm unknown Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 [6 X Could not be Suicide or Town, State) hin 24 hours a...

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valv filled (Specify) Johns Hopkins Hospital Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Wedical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated Lo. 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 1, 2006 30 Name and address of person who complete to Theodore M Vinc JR. cause of deat (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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	/Medic		Magdalene Elizabeth C			1	18	Septe		2006	2.15 am		
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih end Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-1 show any injury or other traumatic event, the Wedteal Examiner must be notified at ance.	H	19a. Informant's Name/Relationship Brenda Lynch / Daught			ing Address (Street and Poplar Grove					Code)		
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	Sta	ate	31. Date liled (Month: Day, Year)	2006 32. Flagistrar's	Signatur	A may			1				
A.	Regist	rar	SEP 0 8	ZUUO JA BUSTONIA	J. J.								

		1 - For Stata Ragistrar	State o	of Maryland /	Depa <i>Cei</i>	artment rtificate	of He	ealth a Death	ınd M	lental Hy	giene Reg. No.	006	28426	
Physici		1. Decedent's Name (First, Middle, Frances Rita Cos								2. Date of De Month SEPT	Day	Year 2006	3. Time of Death 1945 PM	
/Medic Examin		4a. Facility Name (If not institution,	give street and nu	mber) 01 TAC		4b. City, T		Location o				nty of Death	17/0	
Funeral Director		220-24-6072	6. Sex 1 □ M 2√2 F	7. Age (In yrs. last b	oirthday) Yrs.	If Under	Days Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da Mar 12	y, Year)	9. Birthpl Count Mary 1		
the Maryland 28e-f ehow	rector	Usual Residence of Decedent 10a. State 10b. County MD Howard 10e. Street and Number		10c. City, To			Code				10g. Citizen	10d. Inside City Limits 1 □ Yes 2√□ No Og. Citizen of What Country?		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f show entry houry or other traumatic event, its Medical Evantium that the indifficulations.	d by Funeral Director	5320 Dorsey Hall 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Dec Armed Fo ed 1 Tes If Yes, Gi Year or D	edent Ever in U.S. prces? 2 17 No	F	2104	2 ent of His fy Cuban	panic Orig , Mexican Specify:	gin? (Spe , Puerto	ocify Yes or No Rican, etc.)	U.S.A.	lace - America lack, White, e city: Whit	an Indian, atc.	
iled within 72 t tygiene. ther then "natu nt, ice Medica	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 4 17. Father's Name (First, Middle, L.	grade completed) College (1-4or 5+)	(Give life. I	dent's Usual kind of work DO NOT use ng Cle	retired)	iring most		ng (First, Middle,	Cleric		ustry	
should be fi and Mental H ie marked ot aumatic ever		Alfonzo Andreone 19a. Informant's Name/Relationshi	ip (Type, Print)	19	9b. Mailir	ng Address		Clau	dina	Tarant	elli		Code)	
Pages 1 and 2 ent of Health nt: if item 27 i ry or other tra		Anthony Cosentine 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Openation 5 Other (Sp.	3 □Removal from	20b. Place	of Dispo	sition (Nam	e of)	D	Ellico B-2006	20c. Locatio	n - City or Tov		
permit. F Departm Importar eny injur		21. Signature of Furteral Service Li	censee	shert.	1	Name and	Address ulph	of Facility	Ambi	rose Fu g Rd. A	neral i	Home, Md 212	Inc.	
Cate be executed /Medical Examiner /Medical Examiner the brial-transit	dicai Examiner	23a. Part1. Enter the disease, shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	(or as a consequence ACUTE (or as a consequence) (or as a consequence)	e of):		SE	PSIS	\$	RENA			Inierval Between Onset and Death (4 WEEK \$ 4 WEEK	
that the death certifice led by the attending pt detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	1☐Live b	tcome of pregnancy birth 2 Petal dea nant at time of death own		Ectopic pre Other (spe						Date of deliver	y Day Year	
law requires that t as been signed by 2 should be deta	Completed by Ph	Part II. Other significant condition		eath but not resulting	in the ur	nderlying ca	use giver	n in Part I.			res 2 □ No an 24	3 ☐ Proba	a cause of death? bly 4 Denknown sy findings available pletion of cause of	
To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicampletely filled in by the funeral director, page 2 should be detached for use as the	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date	patient 2 ER/C	Outpatien Time of	_	Other	4 □ Nur	sing Hon		rmed? 2 1 No ne dence 6 0	death? 1 Yes 2	2010	
To the Hospitei or Attendii within 24 hours after death. To the Funerei Director: A completely filled in by the fu	Certification;	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place	of Injury - At home, ing, etc. (Specify)	farm, stre	M eet, factory,		es 2 🗆 N		28f. Location (5 City or Tov		mber or Rural	Route Number,	
o the Hosp rithin 24 hou o the Funer ompletely fill	Medical	29a. Certifier (Check only one) 1 □ Certifying 2 □ Medical E.	xaminer: On the b and man	a best of my knowledge asis of examination a ner stated.	and/or inv	estigation,	t the time in my opi	nion, deat	i place, a h occurre	ed at the time,	cause(s) and date and place 29d. Date sign	e, and due to	the cause(s)	
7 3 5 8		30. Name and address of person w	ho completed caus	CHEE MA) (Type,	Print) AA	000 MIR	630	EEN	-	SEPT	5	2006	
Sta Registr		5124 STONE S. 31. Date filed (Morlif), Day, Year) SED 0.8	HOP CIR	CLE, O	WIN	95	MIL	LS	/	MD	21)	117		

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

COSENTINO FR ANCES Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 28427 Certificate of Death 2. Date of Death
Month
SEPTEMBER 6, 2006 1. Decedent's Name (First, Middle, Last) 3. Time of Death 4:40 AM

Physician	
/Medical	
Examiner	

1 - For State Registrar

	Examin	ier	Saint Joseph M	edical Center	Tows		Baltimore
	Funeral Director		10 34 HI HIV	7. Age (In yrs. last birthda)	/) If Under 1 Year If Under 24 Hr Months Days Hours Min		9. Birthplace (State or Foreign Country)
	72 hours after death with the Maryland insturel; or iteme 23e or 28e-1 ehow diget Exeminer must be notified at	ctor	Usual Residence of Decedent 10a, State 10b, County 10c Spanismo	10c. City, Town or ARK	Location		10d. Inside City Limits 1 ☐ Yes 2 🕏 No
	th with th	ai Dire	10e. Street and Number	24 Road	101. Zip Code	10g. 6	Citizen of What Country?
36	be tiled within 72 hours after death with the Marylan Ital Hygliene. Id other than "natural", or iteme 23s or 28s-f ehow event, its Medical Examirar must be collified at	Completed by Funeral Director	11. Marital Status 12 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	. Was Decedent Ever in U.S. Armed Forces? 1	. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 25 No Specify:	Specify Yes or No- into Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-00	72 hou natura	eted	15. Decedent's Educa (Specify only highest grade	tion 16a. Dec	edent's Usual Dccupation re kind of work done during most of w	orking 16b.	Kind of Business/Industry
2121	d within giene. or then	ompl	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	ERATOR S	DOXXS
yland		To Be C	17. Father's Name (First, Middle, Last)	BURT	18. Mother's N	ame (First, Middle, Maid	en Sumame)
Baltimore, Maryland 21215-0036	1 and 2 Health 3 om 27 is ther tre		19a. Informant's Name/Relationship (Type) 20a. Method of Disposition	72.2 H30		IAY PERRY	y or Town, State, Zip Code) 3, 335 ACV ACV Location - City or Town, State
3altimo	permit. Pages Department of Important: if it any injury or o		TS Burial 2 Cremation 3 Red 4 Donation 5 Other (Specify) 21. Sign sure of Fun (al Service Licens le	OAK L	22. Name and Address of Facility	sep Be	Timone MANIANO 4666 COLORERO
	40 5 # a		23a. Part1. Enter the disease, or complication	tions that caused the death. Do not e	EBOO HARFORD	ROPO PAG ac or respiratory arrest,	Approximate Approximate
ı	Pnysician /Medical		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	PNEUMONIA Due to (or as a consequence of):			Interval Between Onset and Death
68760,	icate be executed physicien and physicien and physicien stransit	cai Examiner	Sequentially list conditions, flary, leading to finite date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
.O. Box 68	The law requires thet the deeth certificate be executed to has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 100 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
s, P	uires thet I signed by lid be deta	Ď	Part II. Other significant conditions contributions PULMONARY FIBROSIS	ibuting to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?
of Vital Record	The law require sete has been sig page 2 should b	Completed	CONGESTIVE HEART FA	AILURE		24a. Was an autopsy performed	
Vita	Physician: Th r this certificete ral director, pag	Be	25. Was case referred to medical examiner?	spital:	Other	eath (Check only one)	
ion of	To the Hospitel or Attending Phys Within 24 hours effer deeth. To the Funerel Director: After this completely filled in by the tuneral di	ation: To	1 Yes 2 No Police 27. Manner of Peath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	Home 5 Residence	
Division	ei or Attendi s efter deeth. si Director: A sd in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospitel or Attending within 24 hours effer deeth. To the Funerel Director: Affe completely filled in by the fune	Medical C	(Check only one)	rian: To the best of my knowledge, de r: On the basis of examination and/or and manner stated.	ath consumed at the time data and pla- investigation, in my opinion, death oc	ne, and due to the nauco curred at the time, date a	(c) and matter as exact. and place, and due to the cause(s)
	With With To t	Σ	29b. Signature and trille of certifier		29c. License number D 37254	29d. (Date signed (Month, Day, Year)
	15		30. Name and address of person who com BOON P.LIM M.D.	7601 OSLER DRI		/LAND 2120	14
	Sta Regist		31. Date filed (Month, Day, Year) SEP 0 8 200	32. Registrar's Signature	parte		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM/8. The perfft C859 9/8/06 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death 28428 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Vear **Physician** 2:23 PM 6 Ferguson Jr. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Hospital Sinai Birthplace (State or Foreign Country) Il Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**∑**M 2□ F Director 225-50-1816 66 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b County 10a State 28e-f ehow other traumatic event, the Medical Examiner must be notified at Y☐Yes 2☐No Baltimore Director NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Highgate U.S.A. 238 21215 5812 - 111 -Drive 12. Was Decedent Ever in U.S. Armed Forces? ty□Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Itimore, Maryland 21215-0036 ō 1 ☐ Yes X☐ No Specify: Specify 2 3 Widowed 4 Divorced Black "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Laborer Heavy Equipment 10th grade na 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental is marked Blanche Sumler Willie Ferguson Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5812 Highgate Drive, Baltimore, Md 21215 f Health a Kay Williams-Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Emporia, Antioch Church 9/10/06 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Signature of Funeral Service Licenses 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death on yocardial Immediate Cause (Final 60 min **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit The law requires thet the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. δ 1 ☐ Yes 2 ☐ No 3 M Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No page 2 s Renal Insufficiency Chronic 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☑ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To this After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 3 ☐ Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 - Homicide o the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and titled certifier 30. Name and address of person who ampleted cause of death (Item 23a) (Type, Print) 2401 W. Belvedore Franklin, MD Sinai Hospital Brodenik J. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

SEP 0 8 2006

E	1 - For State Registrar			partment of Hertificate of i		Reg.	ne 2006	28429	
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Joanne Gutkin 4a. Facility Name (If not institution,	give street and number)	BALTIMOR	4b. City, Town, or	r Location of Death	2. Date of Death Month AUGUST	Day 1 Year 2006 4c. County of Deat		
Funeral Director	5. Social Security Number 216-36-9261 Usual Residence of Decedent	111	(In yrs. last birthda 66 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Sept 30,		thplace (State or Foreign buntry) UNK	
ith the Maryland or 28a-1 show as notified at	10a. State 10b. County		Baltimo					10d. Inside City Limits 17 Yes 2 □ No	
urs after deeth with, or iteme 23a pariner must be by Funeral I	10e. Street and Number 1501 N. Duke1a: 11. Marital Status 1 🛣 Never Married 2 🗆 Married 3 🗆 Widowed 4 🗆 Divorced	12. Was Decedent Ev Armed Forces?	er in U.S. 13	10f. Zip Code 212 3. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2∏ No	216 lispanic Origin? (Sp an, Mexican, Puerto Specify:		USA 14. Race - American Indian, Black, White, etc. Specify: White		
led within 72 hou lygiene. her then "netura tt, Ina Medical E Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) unk	grade completed) College (1-4or 5+) unk	(Gir	redent's Usual Occup ve kind of work done o DO NOT use retired	during most of work		b. Kind of Business	/Industry unk	
ould be file Mental Hyg arked other atic event,	17. Father's Name (First, Middle, L	ast)		unk	18. Mother's Name	e (First, Middle, Mai	iden Sumame)	unk	
ages 1 and 2 shr ent of Health and ht: if item 27 is m y or other treum	19a. Informant's Name/Relationsh Sinai Hospita 20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 ☑ Other (Sp	1 3 □Removal from State	2401 20b. Place of Dis	W. Belved position (Name of ematory or other place	lere Aven				
permit. P Departme Importan any injur		icenses Wade Dire	ctor	22. Name and Address State Anat Saltimore,	omy Board	655 W. B	Saltimore	Street	
ate be executed hysicien and hysicien and he burial-transit he burial-transit here.	23a. Fart1. Enter the discussion of sock, or heart failule. List of Immed. Ite Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	MON A	_	UBULL			Approximate Interval Between Onset and Death Wourk.	
es that the death certifica igned by the ettending ph be detached for use as t by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tii 9 □ Unknown	Fetal death	Ectopic pregnancy	,		23d. Date of del Month	livery Day Year	
en signed by ould be deta	Part II. Other significant condition	contributing to death but	not resulting in the	underlying cause giv	en in Part I.			o the cause of death?	
n: The law requirence icete hes been since to hes been since to should Completed						24a. Was an autopsy performed	d? death?	utopsy findings available completion of cause of	
To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate hes been signed by the ettending physicien completely filled in by the funeral director, page 2 should be detached for use as the burian Medical Certification: To Be Completed by Physician/Medical E	25. Was case referred to medical examiner? 1	ot be	/ear) 28b. Time Injury	of 28c. Injury	er: 4 □ Nursing Ho y at k? Yes 2 □ No	h (Check only one) me 5 ☐ Residenc 28d. Describe how 28f. Location (Stree City or Town, S	injury occurred		
ths Hospital on thin 24 hours aft thin 24 hours aft of the Funeral DI impletely filled in Medical Cer	(Check only 2 Medical E	Physician: To the best of xaminer: On the basis of e	my knowledge, de xamination and/or	ath occurred at the tin	ne, date and place, pinion, death occurr	and due to the caus	e(s) and manner as	stated.	
To the within 2 To the comple	29b. Signature and title of certifier	and manner state	r3 S	29c. Licens	e number	00 A	Date signed (Mont	n, Day, Year) 27, 2006	
State Registrar	30. Name and address of person w 31. Date filed (Month, Day, Year)	a Dina	s Signature	1 Danson	SINA	HOSPIT	no of	27, 2006 BALTIMURE	

State of Maryland / Department of Health and Mental Hygien 2006 28430 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** August 25, 2006 10:55 AM Gerald P. Gorman /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis 930 Astern Way #340 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Aug 8, 1920 9. Birthplece (State or Foreign Country) New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Yrs. 115-12-7005 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Annapolis Completed by Funeral Director Anne Arundel MD 10g. Citizen of What Country? 10e, Street and Number ö 21401 USA 930 Astern Way or Items 23a Pages 1 and 2 should be filed within 72 hours after death nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. t XiYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. white 42-54 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 5+ healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nicholas Joseph Gorman Mary Aginz Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health as Important: If item 27 is any injury or other trau once. Jerry Gorman Jr/son 5 Canterberry Road Charlottesville, VA 22901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 L burns.

4 Monation 5 Other

21. Signalure of Functal Service Licensee Onald S. Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that inifiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Aatural 5 Pending 1 ☐ Yes 2 ☐ No М To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 2 Accident investigation filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ertifier D0029571 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) 8 2006 32 Registrar's Signature

		ı	1- State of Maryland / Registrar	Department of H Certificate of L	lealth and Me <i>Death</i>	ntal Hygid Red	ene 2006	28431
	Physici	an	Decedent's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·	2	Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Helen Agnes Green	4h Cit. Town	r Location of Death	9	4c. County of Death	3!15PM
	Examin	er	4a. Facility Name (If not institution, give street and number) TRANKIN SQUARE HOSDIF	4b. City, Town, or	h 15		D . 11	NORE
	Funeral	11	5. Social Security Number 6. Sex 7. Age (In yrs. last)	Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day,)	(ear) 9. Birth	nplace (State or Foreign untry)
	Director		220-22-1611	Yrs.		1/26/1	929 Mar	yland
	yland			own or Location				10d. Inside City Limits
	Ba-fal	Director	Maryland Baltimore Esse:					1 ☐ Yes 2 ☐ No
	death with the Maryland ms 23s or 28s-f show Fraust be rediffed at	Dire	10e. Street and Number	10f. Zip Code			g. Citizen of What Cou	intry?
	ms 23	Funeral	741 Middlesex Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	21 221 13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Specif		U. S. A. 14. Race - Amer	
→ 9	ours after death with the Marylan at', or items 23a or 28a-f show Exacting resulter recities at	/ Fur	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	If Yes, specify Cuba 1 ☐ Yes 2 ☐ XNo	an, Mexican, Puerto Ric Specify:	an, etc.)	Black, White	, etc.
HE FELT 21215-0036	within 72 hours after 6ne. "natural", or ite fre Modical Example	d by	3 △NWidowed 4 □ Divorced Year or Dates:				Specify: Whi	
17 5	in 72 n "nel	Be Completed	15. Decedent's Education (Specify only highest grade completed)	Sa. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	allon during most of working i)	16	6b. Kind of Business/li	·
HE 21215	d with giene or the	Com	Elementary/Secondary (0-12) Coflege (1-4or 5+)	Clerk			United Sta Government	
pu	be filed ntal Hygi od other event, ii		17. Father's Name (First, Middle, Last)		18. Mother's Name (F		aiden Sumame)	
EEN, Maryland	should ind Men ind Men ind marke	ဥ	Joseph Zubrowski 19a. Informant's Name/Relationship (Type, Print) 1	9b. Mailing Address (Street a	Helen Gl		City or Town State Zi	in Code)
_	and 2 sealth an n 27 is			605 Deep Ridg				
altimore,	of He of He of Item		20a Method of Disposition 20b. Place	of Disposition (Name of efery, crematory or other place	Date		Oc. Location - City or T	
E. C	Pages tment of tant: if it jury or o		4 □Donation 5 □Other (Specify) BayV	iew Crematory		В	altimore,	Maryland
Bali	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natureny injury or other treumatic event, Ite Medical ance.		21. Signature of Funeral Service Licensee	22. Name and Addres Bruzdzinsk 1407 Old E	ss of Facility Li Funeral Lastern Ave	Home PA nue Es	sex, Maryl	and 21221
			23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.					Approximate Interval Between
	Physician		Immediate Cause (Finat disease or condition resulting in death)	LRREST				Onset and Death
	/Medical Examiner		Due to (or as a consequence	,	200 100 05	_		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ce of):	corrhage	j		
	ificate be executed g physicien and as the burial-transit	Examiner	Cause (Disease or injury that initiated events c	-4)				
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687	tificate g phys as the	edicai	0.					
XOX	ath certii attending for use a	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal dea	ath 3 Ectopic pregnancy	,		23d. Date of deliv	,
О.	that the death cer ed by the attendir detached for use	ysici	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown	5 Other (specify)			Month	Day Year
Division of Vital Records, P.O. Box	Attending Physician: The law requires that the death certif redath. sector: Atler this certificate hes been signed by the attending by the funeral director, page 2 should be detached for use a	by Physiclan/M	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause give	en in Part f.	23e. Did toba	acco use contribute to	the cause of death?
ords	w require: been sig should be					1 ☐ Yes	2⊠No 3∏Pro	obably 4 Unknown
ecc	e lawr hes be je 2 sh	Completed				24a. Was an autopsy	prior to co	lopsy findings available ompletion of cause of
<u>a</u>	ysician: The is certificate he director, pege		25.11				ZNo 1 ☐ Yes	2 💆 No
=	ysicial s certif directo	To Be	25. Was case referred to medical examiner? 1 □ Yes 3 ☑ No Hospitaf: 1 ▼ Inpatient 2 □ ER/	Outpatient 3 DOA Othe	er: 4 \(\sum \) Nursing Home		ce 6 ⊡Other (Spec	ufv)
10	ding Phys h. After this funeral di	T :uc		Time of 28c. Injury Work			v injury occurred	,
Siol	tendir death. tor: Ai	catle	2 Accident investigation	M 1 🗆 '	Yes 2 □ No			
Divi	el or Attend s efter death si Director: /	Certification;	4 Homicide determined 28e. Pface of Injury - At home, building, etc. (Specify)	tarm, street, factory, office	281	City or Town,	et and Number or Rui State)	'al Houle Number,
	To the Hospitel or Attenwithin 24 hours effer deall To the Funeral Director: completely filled in by the	Medical (29a. Certifier 1 Certifying Physicien: To the best of my knowled (Check only one) 2 Medical Exeminer: On the basis of examination and manner stated.	Ige, death occurred at the lim and/or investigation, in my of	ne, date and place, and pinion, death occurred	d due to the cau at the lime, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License	e number	290	d. Date signed (Month	, Day, Year)
	1		a. FIX mo	Rei	5000) 9	1/6/06	
	5		30. Name and address of person who compfeled cause of death (Item 23:		VII.a Sa	100		110 0 00
	Sta	ite	31. Date filed (Month, Day, Year) 32 Registrar's Signature	200 Flow	Mm 09.	CIK- 120	LITIMORE,	MD 21237
đ	Registr		SEP 0 8 2006 Kingson De	Page 1				

		For State Registrar	State of Maryland	d / Department of F Certificate of I	lealth and Mental	Hygiene 00	5 28432
	ysiciar				2. Date of Month	of Death Day EmBER 6,200	
1	Aedica amine	4a. Facility Name (If not institution, gire	/		r Location of Death	4c. County of De	
Fun Dire		5. Social Security Number 216–36–2272	## 10 Spital C Sex 7. Age (In yrs. I 10 M 2□ F 69		if Under 24 Hrs. 8. Date of Mont. Jan.	of Birth 9. E	Birthplace (State or Foreign Country)
ith the Maryland or 288-1 ehow	flect at	Usual Residence of Decedent 10a. State 10b. County Baltin		r, Town or Location Oundalk			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
h with the	to eq te	10e. Street and Number 7019 Sollers Po	int Rd. 21222	10f. Zip Code	21222	10g. Citizen of What	Country?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland pepartment of Health and Mental Hygiene in natural; or Items 23s or 28s-1 show	Examiner mu	MG. Balti 10e. Street and Number 7019 Sollers Po 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	S. 13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Specify Yes an, Mexican, Puerto Rican, etc Specify:	or No- 14. Race - Al Black, W Specify:	merican Indian, hite, etc. White
Maryland 21215-0036 of 2 should be filed within 72 hours aft in and Mental Hygiene 171s marked other than "natural", or	the Medical	15. Decedent's Elementary/Secondary (0-12) 6 yrs.	ducation ade completed) Coflege (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired N/A	ation during most of working d)	16b. Kind of Busine N/A	ss/Industry
and 2 be filed at other	event,	17. Father's Name (First, Middle, Las			18. Mother's Name (First, M Elizabet		ford
Maryla 12 should h and Mer	treumatic	Edward C. Gulle 19a. Informant's Name/Relationship Douglas Gulled	(Type, Print)		and Number or Rural Route Nos Point Rd. 2	lumber, City or Town, State	
Baltimore, I Demit. Pages 1 and Department of Healt	ry or other	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	20b. P	lace of Disposition (Name of smallery, crematory or other place) VIEW CREMATORY	Sept. 8 2006	20c. Location - City Baltimor	
Balti permit. Departir	any inju	21 Signature of Final Service Lice		Conneily F	uneral Of Dunc ers Point Rd. 2	dalk 21222	
Physic		23a. Part. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		Do not enter the mode of dyin			Approximate Interval Between Onset and Death
/Med Exam	iner	Cognestially list and differen	Due fo (or as a consequence)	uence of):			
ecuted had	rial-transit	Sequentially list condifions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence.	·			
(68760, artificate be executed ing physicien and	the burial	Testing in Gedin/ Last	Due to (or as a consequent of d.	uence of):			
D. Boy	should be detached for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopic pregnancy	/	23d. Date of Month	delivery Day Year
rds, P. I quires that It is signed by	uld be deta	Part II. Other significant conditions Chronic obst	contributing to death but not resu	_	ren in Part I. 23e.	Did tobacco use contribute 1 ☐ Yes 2 ☐ No 3 ☐	e to the cause of death? Probably 4 Dunknown
CTU Record The law requ	page 2 shou	Chronic obst				autopsy prior performed? death	autopsy findings available to completion of cause of ??
of Vital Physicien: The this certificate	rector.	25. Was case referred to medical examiner?	Hospital:	• Oth	26. Place of Death (Check	only one	
- 1	uneral d	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of fnjury (Month, Day Year)	28b. Time of Injury 28c. fnjur Wor		ribe how injury occurred	pecity)
Substantian I Division of Attending after death.	completely filled in by the funeral director, page 2	27. Manner of Death 1 Natural 2 Accident investigative 3 Suicide 6 Could not 1 4 Homicide determined	De 28a Place of Initiat. At he	ome, farm, street, factory, office		ion (Street and Number or or Town, State)	Rural Route Number,
Hospita 4 hours	etely filled	29a. Certifier 1 Certifying P	hysician: To the best of my kno miner: On the basis of examinal and manner stated.	wledge, death occurred at the tir tion and/or investigation, in my o	me, date and place, and due to opinion, death occurred at the	o the cause(s) and manner time, date and place, and c	as stated. due to the cause(s)
To the within 2	сошрі	29b. Signature and title of certifier	tz Q mo	29c. Licens	6 number 5 3 3 / 2	29d. Date signed (Mo	ber 6, 200 C
	X	30. Name and address of person who	completed cause of death (Item				(229
	Stat	31. Date filed (Month, Day, Year)	32. gisfrar's Signa	ture	,		
Re	egistra	SFP 0 8 2	UUb RELIES 1	TO GOODEN			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydien 2006

				State of Mary	/land / Dep	artment o	of Health a	and Me	ental Hy	gien 20		28433
			Registrar		Ce	nificate d	of Death			Reg. No.		3. Time of Death
	Physici	an	Decedent's Name (First, Middle, Last)	١.,					2. Date of Dea Month	Day	Year	2:00 PM
B	/Medic		Lossie Goo						09		0006	3.001 "
	Examir	ner	4a. Facility Name (If not institution, give si				vn, or Location	of Death		4c. County		
			821 N. Augusta			If Under 1 Y	more ear If Under	24 Hrs	O Date of Bird	NIS		lace (State or Foreign
	Funeral		5. Social Security Number 6. Sex		n yrs. last birthday) Yrs.		ays Hours	Min.	8. Date of Birt (Month, Da	v. Year)	9. Birting	itry)
***	Director		239-12-2453		0 1				07/20	71919		NC
	and and		10a. State 10b. County	10	c. City, Town or Lo	ocation					1	0d. Inside City Limits
	Mary	ō	MANNA	1	Baltim	RP						1 X Yes 2 □ No
	28a	Director	10e. Street and Number		20111111	10f. Zip Coo	de			10g. Citizen of	What Cour	ntry?
	Mith Sa or		821 N. Augusta	Ave.		212	29			USA		
	ne 23	Funeral		2. Was Decedent Eve	r in U.S. 13.		of Hispanic Or Cuban, Mexical	igin? (Spe			ce - Americ	
10	r iter	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No					rican, etc.)		ck, White,	etc.
03(ol',o	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ⊔ Yes 216J	No Specify:			Specia	3 lo	ick
21215-0036	within 72 hours after death with the Maryland ane. than "naturel", or itema 23a or 28a-1 ehow na Musical Examiner maal be notilied at	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usual O	ccupation	st of workin	na	16b. Kind of B	Business/Ind	dustry
21	thin .	ple	Elementary/Secondary (0-12)	College (1-4or 5+)			one during mos etired)			<i>a</i> . i		
	filed wi Hygien other th	Sol	12th Grade	NA	Sea	mstre						anufatoring
pu	d oth	Be	17. Father's Name (First, Middle, Last)							Maiden Sumai	m <i>e)</i>	
yla	2 should be filed within and Mental Hygiene. ie marked other than aumatic event, the Ma	2	Frank Braxtor					Ly 5				
Maryland	and and ie m		19a. Informant's Name/Relationship (Typ							er, City or Town		
	1 and Health tem 27 other tr		Leonard Braxton	, (nepher	20b. Place of Dispo				Daltine ato	DRE M		
ore	of H if ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re		cemetery, cre	matory or other	r place)			20c. Location		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel; or iteme 23a or 28a-1 show any injury or other traumatic event, the Madical Examinat rate is notified at Angle.		4 ☐ Donation 5 ☐ Other (Specify)		ARbutu	5 Ceme	etery c	20/65	12006	Paltin	ore,	MD
alt	permit. Departr Imports any inj		21. Signature of Funeral Service License	_	3	2 Name and A	ddress of Facili	he Fu	neral S	1C		
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			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the e cause on each line.	death. Do not en	ter the mode of	dying, such as	cardiac or	r respiratory ai	rest,		Approximate Interval Between Onset and Death
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P.O.	that the death certificate ed by the attending phys detached for use as the	P	Part II. Other significant conditions con	tributing to death but n	ot resulting in the u	inderlying caus	e given in Part	l,	23e. Did to	obacco use con	tribute to th	he cause of death?
ds,	tw requires that s been signed b should be det	by							10	res 2. VNo	3 🗌 Prob	pably 4 Unknown
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isi	deatl deatl ctor: / the	Ical	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At home, farm, st				28f. Location (Street and Num	ber or Rura	al Route Number,
Division of Vital Records,	or A after Direction by	erti	4 ☐ Homicide determined	building, etc. (Specify)	,,,			City or Tox	vn, State)		
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:	29a. Certifier 1 Certifying Phys	ician: To the best of n	ny knowledge, dea	th occurred at the	he time, date ai	nd place, a	and due to the	cause(s) and m	anner as s	tated.
	24 h 24 h Fun etely	dica		er: On the basis of ex	amination and/or in							
	o the	Me	29b. Signature and title of certifier			29c. Li	icense number			29d. Date signe	ed (Month,	Day, Year)
	r s ⊢ ō		A mathew w	D.		02	17716			9-6-	06	
	. 0		30. Name and address of person who co		h (Item 23a) (Tyne	Print)						
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			1 - For State Registrar	State of N	Maryland /		artment of H		and M		iene 9. No 20	06	28434
	Physici		1. Decedent's Name (First, Middle,							2. Date of Death	Pay	Year	3. Time of Death
	/Medic Examin		Baby Boy Howel 4a. Facility Name (If not institution, g		or)		4b. City, Town, or	Location o	of Death	HUGUST	4c. Count	y of Death	0343 "
		-	The Johns Nook	ns Hospit	77		Baltim	we (city	(
	Funeral Director		none	1 Sex 7. A	Age (in yrs. iast i	oirthday) Yrs.	If Under 1 Year Months Days	If Under : Hours	Min.	8. Date of Birth (Month, Day, Aug 26,		Coun	lace (State or Foreign itry) yland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation					1	Od. Inside City Limits
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	or 28	Direc	10e. Street and Number				10f. Zip Code			10	og. Citizen of	What Coun	itry?
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36	or ite	by Funeral Director	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	s? ⊠No		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2X No	Specify:	gin? (Spe i, Puerto F	city Yes or No- Rican, etc.)	Bla	ce - Americ ack, White, fy: bla	etc.
21215-0036	"natural",	ted	15. Decedent's (Specify only highest	Education			dent's Usual Occup kind of work done		t of working	20	16b. Kind of E	Business/Inc	dustry
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Maryland	should be i and Mental I s marked o umatic eve	To Be	Raymond Burn							Howell	aroon sama		
ary	2 should be and Mental is marked sumatic ev	۲	19a. Informant's Name/Relationship		19		ng Address (Street	and Numbe	r or Rura	l Route Number,	-	, State, Zip	Code)
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o o	permit. Pages 1 Department of He Important: if Iter any injury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 ☒ Other (Spe	. □Removal from Stat cify) in stat	te cemei	of Dispo tery, cren	sition (Name of natory or other plac	(9)	D	ate 2	20c. Location	- City or To	wn, State
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Vital	Physician: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?	Uponital, and			100		of Death	(Check only one	9)		
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=	al or Atter s after dea al Director ed in by the	Certification;	3 Suicide 6 Could not determine	ad 286. Place of I	Injury · At home, etc. (Specify)	farm, str	eet, factory, office		2	28f. Location (Str City or Town	eet and Numi , State)	ber or Rura.	l Route Number,
	To the Hospital or Attending Phymitin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a, Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best aminer: On the basis and manner:	of examination a	ge, death and/or inv	n occurred at the tin vestigation, in my o	ne, date and pinion, deat	d place, a th occurre	and due to the ca ed at the time, da	use(s) and m ite and place,	anner as st	ated. the cause(s)
	To the comp	Σ	29b. Signature and title of certifier				29c. License	number		29	d. Date signe	d (Month, I	Day, Year)
								185	3		8/	26	12006
			30. Name and address of person wh	io completed cause of	f death (Item 23a	(Type,	Print) NOCTO LAI	Olpo 9	STroi	ET RAH	IVANCO . I	11.0001	2006 rd 21287
199	Sta	te	31. Date (iled (Month, Day, Year)	32 Aegis	strar's Signature	A SE	001 (000	Ju	-(, (1100	urwe)1	THY CH	ra 2081
	Registr		0	2006	As Is	A STATE	Je Jakon M						

State of Maryland / Department of Health and Mental Hygiene 2006 28435 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician Leon Sylvan Hudnall 8 2006 7:10 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3543 Liberty Heights Avenue Balto If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Months Hours 218-26-8570 75 Director 11-11-1930 Md Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show or than "natural", or Itema 23a or 28a-f shov The Mudical Expression to modified at Y Yes 2 □ No Md N/A Balto Direct 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 3543 Liberty Heights Avenue 21215 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1∕E) Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced ted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Complet Jewish Family Services College (1-4or 5+) N/A 27 is marked other than traumatic event, the Ma Elementary/Secondary (0-12) Maintenance Engineer 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H Be Leon Chandler Jessie Hudnall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tem 27 other tra Louise Hudnall - Wife 3543 Liberty Heights Avenue Balto, Md 21215 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If Its any Injury or ot 2008. 1 Burial 2 □ Cremation 3 □ Removal from State King Memorial Park 9/5/2006 Randallstown, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician OURREVS uulting disease or condition resulting in death) /Medical Due to (or as a con equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physicien and s the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending for use as as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should l Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 212 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) se of death (Item 23a) (Type, Print) 5601 Revery Registrar's Signature State Registrar

			1 - For State Registrar	State of Maryland / De	partment of He ertificate of D	ealth and Me Death	ental Hygien	2006	28436
ı	Physici	an	1. Decedent's Name (First, Middle, Last,	•			2. Date of Death Month D	ay Year	3. Time of Death
	/Medic	al	E1iza 4e. Fecility Name (If not institution, give	Ha.	mm 4b. City, Town, or L		eptember	c8,2006	1:18A M
	Examin	ier	9114 Ridge Woo	·		shingto			Georges
	Funeral Director		5. Social Security Number 6. Se 229-05-4998		Months Days	If Linder 24 Firs.	8. Date of Birth (Month, Dey, Yea Aug • 18,	9. Birth	place (State or Foreign intry)
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
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	or 28	Director	10e. Street and Number		10f. Zip Code		1	Citizen of What Cou	untry?
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220	filed within 72 hours after death with the Maryland Hygiene yther than "natural", or fleme 23a or 28e-f ahow ant, the Medical Extrainmer court be meilled at	by Funeral	11. Marital Status 1 Never Married 2 Married 3x3vidowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, specify Cuban	Specify:	ican, etc.)	Black, White	
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	ges 1 and 2 should be filed within it of Health and Mental Hygiene. If item 27 is marked other than or other treumatic event, the Mental County, t		19a. Informant's Name/Relationship (T)		alling Address (Street an		-		
≥ ນົ	s 1 and 2 of Health item 27 i		Linda Hamm Wall 20a. Method of Disposition	ker-Daughter 91	14 Ridge	Wood Dr		ashingto Location - City or T	
5	Pages nent of H int: # ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	rematory or other place) Grove Cem)	4.	Lliamsbu	
	그는만등		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 	<u></u>	22. Name and Address	of Facility		. I I GIII D.O.C	
Ď	Departing Department of the partment of the pa		Probert B 1	Saker Hr.	Whiting 7345 Poca enter the mode of dying,	Funeral	Home Trail Wi	11iamel	23185
	Physician		23a. Pert1. Enter the disease, or compleshock, or heart failure. List only of immediate Cause (Final disease or condition	lications that a used the death. Do not a ne cause on each line. AIZheim		, such as cardiac or ement			Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):		-11/C/J1			years
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O. DOX	o the Hospitel or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. The certificate has been signed by the attending physician and to the Funerel Director: After this certificate has been signed by the attending physician and the place in the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of deliv Month	ory Day Year
L ^	s that med b	by Pt	Part II. Other significant conditions co	ntributing to death but not resulting in the	underlying cause given	n in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ecords,	equire sen sig ould b	ted	Diabetes	Mellitus			1 ☐ Yes	2⊠No 3□Pro	bably 4 DUnknown
נו	B 25 CA	Completed	Hyperter	15ion			24a. Was an autopsy	prior to co	opsy findings available ampletion of cause of
2	eician: The law s certificate has E lirector, page 2 s		/				performed? 1□ Yes 2,⊠ N		2 No
VIIA	reicia: s certii directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	Othor	26. Place of Death	(Check only one) e 5 Residence	6 A Other /Snec	Dayshiers
5	ig Phy ter this neral o		27. Manner of Death	28a. Date of Injury (Month, Day Yeer) 28b. Time	of 28c. Injury a	at 28	3d. Describe how inj		nome
	eath. or: Af the fu	catic	1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			es 2 No			
2	tel or Att rs after d el Direct ed in by	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	21	Bf. Location (Street and City or Town, Sta		ral Route Number,
	o tha Hospitel or Attending Physician: The tritin 24 hours after death, to the Funerel Director: After this certificate has the Funerel Director. After this page of the funeral director, page	Medical		sician: To the best of my knowledge, de iner: On the basis of examination and/or and manner stated.					
	5	Σ	29b. Signature and title of certifier	1-1 1 +	29c. License	_		ate signed (Month.	
			"Seling D	Obshington		2800		9-8-	
(U		30. Name and address of a r on who co	ompleted cause of de (th (Item 23a) (Typ	e, Print) 1 Livingst	on Kond#	205 II	Washingh	n Morula Jonuc
	Sta		31. Date filed (Month, Day/Year)	32. negisirai s Signature	Constit ?	v. 1 / Vulley	20 11.	National Property of the Parket of the Parke	1 1216 71914 20 /17
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 3, 2006 **Physician** Chester B. Hahn 10:40 pm /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Pennsylvania 83 Director 190-14-5691 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show item 27 is marked other then "natural", or items 23e or 28a-f show other treumatic event, the Medical Examples for must be contilled at 1 Yes 2 No Harford Directo Md. Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 807 S. Fountain Green Road 21015 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 □XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: 3 ☐Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) steel industry laborer 12 years if Health and Mental Hygi item 27 Is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill timent of Health and Mental Hytent: If item 27 Is marked oth Be Gladys Johnson Unknown 19a. Informant's Name/Relationship (Type, Print)
Betty Groff Executor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 807 South Fountain Green Road, Bel Air, Md. 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any njury or once. 9/7/06 Allentown, PA Woodlawn Mem. Pk. * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. Buan a Will 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial infarction /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medicai for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ atrial fibrillation, depression, anemia, 2 XNo 3 Probably 4 Unknown Completed peeu Parkinson's disease, dementia, legally blind 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 certificate 1 Yes 2√ No or Attending Physician: 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ∐ Yes 2 ∐Xio this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: After 1 Natural 5 Pending Lhours after death. Lunerel Director: Aft sly filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

2006

State of Maryland / Department of Health and Mental Hygiene Reg. N. 2 U U 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 5:45 p ^м August 29, 2006 Hall <u>Mercedes</u> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Westminster Summerville Assisted Living If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day Yea July 27, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 7^{Year)}1907 **Funeral** Mary land 99 Director 214-14-8090 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "netural", or items 23a or 28a-f show other treumetic event, the Medical Examinar must be recitived at 1 ☐ Yes 2 No Westminster Carrol1 Md. Director 10f. Zip Code 21157 10g. Citizen of What Country? 10e. Street and Number 45 Washington Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 22 No If Yes, Give Year or Dates: 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify þ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 8 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mercedes Tallon William Bandel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15016 Wheeler Road, Sparks, Md. 21152 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tret <u>once</u>. Melvin Herzberger/grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/2/2006 Bel Air, Md. Bel Air Mem. Gdns. `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Schimunek Funeral Home of Bel Air, Inc. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pnysician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760. the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 1 ☐ Yes 2 **N**O Hospitel or Attending Physicien: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 Yes 2X No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Re, Westmister, MD2/157 30. Name State Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 28439 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day September 5, **Physician** Herbert E. Hickey, Sr. 2006 7:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Baltimore Gilchrist Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 16, 1928 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 11 M 2□ F 217-22-3376 78 Yrs. Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show I Health and Mental Hygiene. Item 27 is marked other than "neture!", or Iteme 23a or 28a-1 shov other traumstic event, the Medical Example invalid at Director 1 ☐ Yes 2 🙀 No Maruland Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 4104 B Chardel Road U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Importent: If them 27 is marked other than "naturel", or iteme 23e eny injury or other traumatic event, the Manthalland. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year, or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Draftsman Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Wheeler Joseph P. Hickey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica D. Hickey (wife) 4104 B Chardel Road, Nottingham, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lakeview Mem'l Park 9/8/2006 Sukesville. Maryland 22. Name and Address of Facility Schimunek Functul Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician week disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physicien and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown 9 Unknown ate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Tyes 2□ No : After this certifical funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Pother (Specify) has pure Medicai Certification; To 1 Yes 2 № No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1-Watural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number D 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARLON CHARLES WO GCO! No Charles Barmore no zeroy 51 Aron Charles 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 0 8 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fth 9860 10-5-06 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. N.2 0 0 6 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day OLLAND Year Physician 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Howard ounty General Hospital Columbia
If Under 1 Year | If Under 24 Hrs. **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 🗷 F Min. Yrs Director 220-30-9864 02/05/1935 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other then "natural", or Items 23a or 28a-f show ury or other traumatic event, it e Medical Evanther must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Completed by Funeral Director Howard Ellicott MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5320 DR JESTAK orsethal 31043 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Black Specify: 3 ₩Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home maker Domestic NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Nickens 2 Fannle Mae Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15302 Lyons Den Rd. Burtonsville, MD 20866 Koslvo D. Clark 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of the Important: If Its any Injury or of once. 1 ■ Burial 2 □ Cremation 3 □ Removal from State Baptist Church ¹ 4 □ Donation 5 □ Other (Specify) 09/11/2006 Columbia MD 22 Name and Address of Facility Funeral Svc Vaugin C. Greene Funeral Svc 5151 Bato Natt Pike Bath 21. Signature of Funeral Service Licenses aughn Greene Baltimore MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): ardioNASCH av DICENSE **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner To the Hospital or Attanding Physician: Tha law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown page 2 should Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 We 2 No 1 ☐ Yes 2 1 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide within 24 hours at To tha Funeral D completely filled i filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 SVITE ARMORI 300 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

		1	For State Registrar	State of	Maryland / Del	partment of I partificate of			iene ag. N 2006	28441
**(Dhysiair		Decedent's Name (First, Middle, L		1. ~ ^ ~	2		Date of Deat Month	O \\/	3. Time of Death
	Physicia /Medic	al -			Horryna			Month	4c. County of Dea	
	Examin	51	4a. Facility Name (If not institution, g. LAULUS MENIEWA			40. City, Town,	or Location of Deal	,n		GENRE
2 (17)	Funcial				. Age (In yrs. last birthda	(v) If Under 1 Year	If Under 24 Hrs	8. Date of Birth	9. Bir	thplace (State or Foreign
1 Mg.	Funeral Director		577-76-3175 Usual Residence of Decedent	1 □ M 2 🗷 F	ר Yrs.	Months Days	Hours Min	(Month, Day,		ountry) VA
	/land		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Man a-f sh	io	MD Anne.	Arundel	Laure	\				1 ☐ Yes 2 🗷 No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	ath w	la l	205 Sycamore		Road dent Ever in U.S. 1	307a	. 1	Specify Ves or No-	14. Race - Am	erican Indian
	item item	Funeral	 Marital Status Never Married 2 Married 	Armed For		 Was Decedent of If Yes, specify Cui 		to Rican, etc.)	Black, Whi	
920	urs af al', or	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Da		1 ☐ Yes 2 🗷 No	Specify:		Specify: B	ack
21215-0036	72 hours after death with the Maryland natural; or Items 23e or 28e-f show oral Examinat . Mat be notified	Completed	15. Decedent's (Specify only highest of	Education trade completed)	(G.	cedent's Usual Occu	e during most of we		16b. Kind of Business	
121	vithin ne. hen.	mpl	Elementary/Secondary (0-12)	College (1-	4or 5+)	DO NOT use retir	•		Domestic	^
	filed within Hygiene. Ither than " ont, Ine Mo	e Co	17. Father's Name (First, Middle, La.	St) UNK	ITUN	ie make		me (First, Middle, i		
an	Duid be Mental arked o	To Be					Minnie	Pugh		
Maryland	is to E E	-	19a. Informant's Name/Relationship	(Type, Print)		-	et and Number or F	lural Route Number	City or Town, State,	Zip Code)
	1 and 2 Health a iem 27 la		Nicole L. Koyal	(daughter	205	Sycamore Posposition (Name of	Ridge Rd, 1	-aurel MI	20c. Location - City of	Town State
Baltimore,	ges to the life or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		state cemetery, o	rematory or other pl	ace)			
Ħ	permit. Page Department o Important: If any Injury or once.		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lie		Itt, Lin	22. Name and Add Youghn	ress of Facility	06/2006	Brentwood	, MD
Ba	permit. Departr Imports any inje		Vaucha ((77	ano.	Vaughn C	. Greene	to Palti	note, MD	21229
	3 8		23a. Part1. Enter the disease, or co shock, or heart railure. List on	mplications that ca	used the death. Do not					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Thomas	- GIBRI	datur	1		Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a consequence of):					48 HEMS
	Examine	16	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		or as a consequence of):	whenthy				10 11011
8	nsit	Examiner	Cause (Disease or injury	200.0						
ر ا	be executed ician and burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as a consequence of):					
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x 68	eath certificat attending phy I for use as thi	Physiclan/Med	IF FEMALE:	23c If yes out	come of pregnancy				23d. Date of de	playen
Вох	attend for us	clan	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live b	rth 2 Fetal death	3 ☐Ectopic pregnar 5 ☐ Other (specify)			Month	Day Year
P.O.	0 0 0	hysi	1 □ Yes 2 VS No 9 □ Unknown	9☐Unkno						
œ,	requires that the een signed by th nould be detache	by P	Part II. Other significant condition			e underlying cause of	given in Part I.			to the cause of death?
ord	w require been signal	ted	hurs nom							Probably 4 Aunknown
ec	law as b 2 st	Completed	Never RUSA	12AZM	y Prewne	-		24a. Was a autop perfor	sy prior to	autopsy findings available completion of cause of
alF	icien: The certificate har rector, page		IMPER CHOIES	TENUZE	MA	·	00 Di of D	1 ☐ Yes	2 No 1 Y€	s 2 XXV o
Zi.		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	npatient 2 ER/Outpa	itient 3 DOA		eath <i>(Check only or</i> Home 5 ☐ Resid	ence 6 □Other (Sp	ecify)
1 0		-	27. Manner of Death		of Injury 28b. Tim h, Day Year) Inju	e of 28c. In			ow injury occurred	
ion	Attending in death. sector: After by the funer	atlo	1 Natural 5 Pending 2 Accident investiga	tion	n, bay roary		☐Yes 2☐No			
Division of Vital Records,	after de Directe	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	289. Place	of Injury - At home, farm ng, etc. (Specify)	, street, factory, offic	e	28f. Location (S City or Tow	itreet and Number or I m, State)	Rural Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical C	(Check only 2 Medical Ex	caminer: On the ba	best of my knowledge, of asis of examination and/o	leath occurred at the or investigation, in m	time, date and pla y opinion, death oc	ce, and due to the courred at the time, of	cause(s) and manner a date and place, and di	as stated. ue to the cause(s)
	To the within 2 To the complet	Med	one) 29b. Signature and title of sentition	and mani	ner stated.	29c. Lice	ense number		29d. Date signed (Mo	nth, Dey, Year)
	F × F 8		1	2	~ 0	0	36974		SEP 1 2	006
	3		30. Name and address of person w		e of death (Item 23a) (Ty	pe, Print)			Cours	n mo ziriq
	St Regist	ate s	31. Date filed (Month, Day, Year)	2006	egistrar's Signature	Speedi				

State of Maryland / Department of Health and Mental Hygiene, 28442 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUS7 2000 **Physician** M. Harvey Jacqueline 9:57a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Future Care Lochearn If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 10 M 20 F Yrs. 216-32-5201 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10h. County 10d. Inside City Limits Yes 2□No Director Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "naturel", or items 23s or items 23s or items Medical Examinar must be r 21216 USA 2821 Elgin Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced Black "naturel" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "re any Injury or other traumatic event, it a Mod ORCE. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade l year Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Matilda Gray Bernard 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8317 SunnyBrook Ct., Brandywine, Md. Renee Sutton Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-29-06 Loudon Park Cem. Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 1101 E. North Ave. March F.H. East 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final END STAGE ISCITEMIC CARDIOMYOPATHY

Due to (or as a consequence of): Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to ror as a consequence of Examiner The law requires that the death certificate be executed nding physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐ Pregnent at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by CHROMC KIDNEY DISEASI-1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Miknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CHRONIC LING DISEASE autopsy performed? MAYTHMIA CARDIAC 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury al Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number H45931 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) and Heights Avenue Rallmene MD Deburah I PLONE 31. Date filed (Month, Day, Year) 8 2006 32. Registrar's Signature, State Registrar

			1 - For Stata Registrar		State of N	Maryland / D	epartment of l	Health and M <i>Death</i>		gien 2 006 Rag. No.	28443
	Physici	e ian	1. Decedent's Name		-	1	· -		2. Date of Dea	Day Yea	
	/Medi Examir	cal	Lila 4a. Facifity Name (If	Marie f not institution, giv	Hall e street and numbe		4b. City, Town,	or Location of Death	264	4c. County of D	
100	LAdiiii		SAINT	AGNES	11		BALTIN	1010	10	N/A	A
8	Funeral Director		5. Social Security No. 217-34-3 Usual Residence of	3794	Sex 7. A	Age (In yrs. last birti	hday) ff Under 1 Year Months Days		8. Date of Birt (Month Day Mar. 15,	^h 1923 No.	Birthplace (State or Foreign Country) rth Carolina
	yland		10a. State	10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Ba-1 al	ector	MD		imore		Lansdown	e ·			1 ☐ Yes 2 No
	with th	Dire	10e. Street and Nun				10f. Zip Code	21227		10g. Citizen of What United Sta	
980	2 should be itled within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or itame 23a or 28a-f ahow aumatic avent, the Mexical Exacting frotal be notified at	by Funeral Director	11. Marital Status	ed 2 Marned	12. Was Deceder Armed Forces 1 Yes 2X If Yes, Give Year or Dates	s? JNo	13. Was Decedent of If Yes, specify Cut		ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian,
5-0036	72 ho	Completed	(Spec	15. Decedent's E			Decedent's Usual Occu (Give kind of work done	during most of work	ing	16b. Kind of Busine	ss/fndustry
2121	within iene. then	dmo	Elementary/Secon	ndary (0-12)	Colfege (1-4o	r 5+)	life. DO NOT use retire Nurse	ed)		Hospi.	tal
Maryland 2	ges 1 and 2 should be filed within 72 ho it of Health and Mental Hygiene. If item 27 is marked other then "natur or other traumetic event, the Medical	To Be Co	17. Father's Name (William Hal)				e (First, Middle, Valton Ho	Maiden Surname)	
	and 2 shorally and N 27 is ma		19a. Informant's Na Warren L. H		Турө, Print)		Mailing Address (Stree Third Avenue				e, Zip Code)
Baltimore	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra ance.		20a. Method of Disp Burial 2 [Cremation 3	Removal from Stat		Disposition (Name of crematory or other plans)		Date	20c. Location - City	or Town, State
ıltir	permit. Pa Departmer Important any injury		4 Donation 21. Signa III b Fu	5 Other (Special neral Service Lice		Campins	22. Name and Addr	ess of Facility Andre	006 	_Marciottsv cal Home, In	ille, MD
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	Physician /Medical Examiner		shock, or hear lmmediate Cause (disease or condition resulting in death)	rt failure. List only Final	a. Hypox	line. LIC HYP	ot enter the mode of dy	_			Approximate finterval Between Onset and Death
8760,		dical Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or that initiated events resulting in death) L		b. ONGE Due to (or a	IS A CONSEQUENCE OF STUE IS A CONSEQUENCE OF STEPPS EXTENSION OF STEPPS IS A CONSEQUENCE OF STEPPS EXTENSION OF STEPPS IS A CONSEQUENCE O	HEART TIBROS	FAILUR		.,, (1),	2 WEEKS 2 WEEKS
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P.O. Box 6	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown Part II. Other significant of the past 12 1 ATE	pregnant months?	b. ONGE Due to (or a c. PULM Due to (or a d. HYPE 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	Is a consequence of NARY Is a consequence of PTENS The of pregnancy 2 Fetal death at time of death but not resulting in	f): HEART f): TIBROS f): 3 Ectopic pregnance 5 Other (specify)	FALLUP SIS ven in Part I.	23e. Did to 1	23d. Date of Month bbacco use contribute fes 2 No 3 2 an 24b. Were sy med? an 1 Yes	2 WEEKS 2 WEEKS delivery Day Year to the cause of death? Probably 4 [Minknown autopsy findings available to compfetion of eause of
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	/Medic	al	Veronica Henner 4a. Facility Name (If not institution, give			4h City	Town or	r Location of	of Death	SEAT	40 COI	2006 unty of Death	7.13 17	
	Examin	er	Catonsville Common		ome	40. 01.9		nsvil			10.000	-	imore	
	Funeral	3	Social Security Number 6. S	ex 7. Age (In	yrs. last birthda	y) If Unde	r 1 Year Days	If Under Hours	24 Hrs. 8	B. Date of Birtl (Month, Day	Year)	9. Birthp	place (State or Foreign	_
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	and ow		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or	Location						1	0d. Inside City Limits	_
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21215-0036	be filed within 72 hours after death with the Marylar Ital Hygliene. d other than "natural", or Items 23a or 28a-f show event, the Maziral Examinat must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. De	cedent's Usu ve kind of wo b. DO NOT to	al Occup	ation during mos	st of working	g	16b. Kind o	of Business/In	dustry	
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<u>lan</u>		To B	Stephen N. Gregor					V.	landa	W. Bar	tosev	ich		
Maryland	and and		19a. fnformant's Name/Relationship (Type, Print)	19b. Ma	iling Addres	s (Street	and Numbe	er or Rural	Route Numbe	r, City or To	wn, State, Zip	Code)	
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	/Medical Examiner			Due to (or as a cor	sequence of):								•	
d	71.5%	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a cor	sequence of):									-
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	12		30. Name and address of person who	completed cause of death	(Item 23a) (Typ	e, Print)	1	1 /	gters	11.71	¥./	~	00/	_
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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2006 28445 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Augus. eola 9:30 UM Lsaac 200€ 70 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Frederick Villa Nursina Home atonsville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□ M 25 F Months 246-20-3399 Usual Residence of Decedent Yrs. Director 04/04/1925 permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event. 10a State 10d. Inside City Limits 10b. County 10c. City, Town or Location Gwynn 1 ☐ Yes 2 1 No Director MD Baltimore Oak 10e. Street and Number 10g. Citizen of What Country? 4708 Ave 21201 Norwood Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 Ø No Specify: 2 3 X Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grade maker)omestic NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) (△↑★ Be Kussell ဥ Lizzie Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town (daughter) Jacobs 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest 9/7/2006 Ewings Mills, MD 22. Name and Address of Facility Vaughn C. Greene 21. Signature of Funeral Service Licensee Funeral 5151 Balto, Matt Pike, Baltimore MD 21229 Greene 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail (re) List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical WEEKS - NUTRITION Examiner Physician/Medicai Examin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ANDIOMYOPATHY þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 20 No 1□Yes 2□No 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA edicai Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Records, P.O. Box 68760, of Vital

The law requires that the death certificate be executed

Hospital or Attanding Physician: after death To the Hospital or Atta within 24 hours after de To the Funaral Directo completely filled in by ti

3

29a. Certifier

29b. Signature and title of certifier

29c. License number D0061765

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

WILLICENS AVE #307 BALTIMONE IMP 3350 OCUMENDO EBEN 72Fn

State Registrar 31. Date filed (Month, Day, Year) SEP 0 8 2006 32. Registrar's Signature

Tanya G. Jessop 06-06647

Please Type or Print in Black Indelible Ink

UNK UNK State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Medical Examiner Month Day September 5, 2006 1023 hrs Tanua G. Jessop 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death Finksburg Carroll 3202 Murray Road 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Director Country) Kentucky 1 M 2 X F Feb. 3. 1980 26 213-96-3373 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits any Yes 2 X No 28a-f show Maryland Baltimore with the Maryland Director 10g. Citizen of What Country 10e Street and Number 21236 U. S. A. 4108 Loch Lomond Drive Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married hours after death Yes 2 X No White 1 Yes 2 X No specify: 3 Widowed Divorced If Yes, Give Year Specify traumatic event, the Medical Examiner ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industr Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "r or other traumatic event, the Medical F. College (1-4 or 5+) Baltimore, MD 21215-0036 N/A12th Grade N/A 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James J. Jessop Gail L. Hofferbert Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jame<u>s</u> J. Jessop (Father) 4108 Loch Lomond Dr., Baltimore, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State permit. Page: Department o Important: 09/08/2006 Baltimore, Maryland Bayview Crematory Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Road, Baltimore, Maryland 21236 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Narcotic and cocaine intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Physician/Medical X UNPENDED attending physician for use as the burial -AMENDED item#23a,27,28a-f,perME,g859,9/15/06 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If ves, outcome of pregnancy 23d Date of delivery 23b Was decedent pregnant in the 3 Ectopic pregnancy Live birth Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy After this certificate has performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 V Yes 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 5 Pending Director: Fnd 9/5/2006 Fnd 10:30 pm unk 2 Investigation Accident 28f Location (Street and Number or Rural Route Number, City or Town, State) 3202 Murray Rd Finksburg, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be determined (Specify) house Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. September 6, 2006 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) SEP 0 8 State 2006 Registrar

		•	1 - State Registrar	State of Maryland	4/06 ^{pg}	rtment of F tificate of	lealth and Death	Mental Hy	giene 2	006	28448
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-	Q		30. Name and address of person who com	pleted cause of death (Item	23а) (Туре,	Print)	os putal	Balt	mors	e	
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9 e	physician and s the burial-transit	dicai		d					<u>-</u>									
diffica	ng pr	Med	IF FEMALE:															
ath ce	or use	an/	23b. Was decedent pregnant in the past 12 pronths?	1	1 Live	tcome of birth 2	Fetal	death 3		oregnancy					23d. Dat	te of delive	,	rear
e de	been signed by the attending p should be detached for use as	Physician/Me	1 ☐ Yes 2 No 9 ☐ Unknown		4∐Preg 9∐Unkr	nant at ti nown	ime of de	eath 5[] Other (s	pecify)				-	1000		Juy .	ou.
thatt	detac		Part II. Other significant condition	ons contrib	uting to d	death but	not resu	ulting in the u	inderlying	cause give	en in Part I.		23e. Die	d tobac	co use conti	ribute to th	e cause of d	eath?
S S S	ngis r	d by											10	Yes	2 0 No	3 Prob	ably 4 □U	Inknown
	shou	Completed											24a. Wt	as an	24b. \	Were auto	psy findings a	available
L el	age 2	E											aui pei 1 ☐ Yes	topsy rformed 2 D	1?	orior to co death? I∐Yes		iuse of
0u:	tor, p	a	25. Was case referred to medica								26. Place	of Death	(Check only		740	163	2 140	
nysic	direc	To B	examiner? 1 ☐ Yes 2 ☑No	Hosp	ital: 1 V	Inpatien	t 2 🗆	ER/Outpatie	nt 3 🗆 🗅	OA Othe	er: 4 □ Nu	rsing Hon	ne 5□Re	sidence	e 6 □Oth	er (Specif	1)	
- E	unera		27. Manner of Death Natural 5 ☐ Pendir	19 2	8a. Date (Mor	of Injury	Year)	28b. Time o Injury		28c. Injury Work			8d. Describ	e how i	njury occurr	red		
tend Jeath	the fi	cati	2 Accident investigned investigation investigat	not be	0 84				М		Yes 2□I		104 4:	(0)				
or Al	in by	Certification:	4 Homicide determ	iined 2	8e. Place build	e of injur	(Specify	me, farm, st	reet, facto	ry, office		-	City or T	Town, S	tate)	er or Hura	l Route Num	⊅9 <i>1</i> ,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	- 1	29a. Certifier	ng Physicia	in: To th	e best of	my kno	wledge, deat	h occurre	d at the tim	ie, date an	d place, a	nd due to th	ne caus	e(s) and ma	nner as si	ated.	
he Ho	pietely	Medical	(Check only 2 Medical one)	Examiner:	On the b	basis of e	ed.	tion and/or in	vestigatio	n, in my op	oinion, dea	th occurre	d at the time	e, date	and place,	and due to	the cause(s	
With	0 00	Σ	29b. Signature and title of certifie	1	^-				25	c. License	number	. 7		29d.	Date signed	d (Month,	Day, Year)	1001-
	12			, , , , ,	J (N))				כ ע	8 50	, 5		>	Losa	wier	10	مردد
	0		30. Name d address of person	who compl	eted cau	ise of dea	ath (Item	23a) (Type	Print)	u 51	T 851	ATU	me	M	21	204	_	
	Sta	te	31. Date filed (Month, Day, Year)	1003.	32. 1	Registrar	r's Signa	ture ga	A Company	e a							ated. the cause(s Day, Year)	
F	Registr		crn A	8 200	6	SPAR	i Ber	My J	A STATE OF THE STA									

			For State	State of M	aryland	d / Depa	artment of H <i>tificate of</i>	Health and M Death	ental Hyg	iene 20	06	28451
	- Sag		Registrar 1. Decedent's Name (First, Mid			061	uncate or	Dealli	2. Date of Dea	th		3. Time of Death
	Physici /Medio		Marie M.	Kalendek				9	Month Sept.	Day 4_2006	Year	1326 _м
	Examin		4a. Facility Name (If not institut.				4b. City, Town, o	or Location of Death		4c. County of		
		, M	Upper Chesa		o //m van le	a thirthdail	Belai:		8. Date of Birth	Harf		lane (Chita na Farria)
	Funeral Director		5. Social Security Number 213-36-5960	6. Sex 7. Ag	68 (In yrs. 18	ast birthday) Yrs.	Months Days	Hours Min,	Month, Day	, Year)	Coun MD	lace (State or Foreign try)
			Usual Residence of Decedent							,		
	the Marylan 28a-fehow	'n	MD H	arford		, Town or Lo Edgev					11	0d. Inside City Limits 1 ☐ Yes 2X No
	the Maryla r 28a-f ehor	rect	10e. Street and Number		1		10f. Zip Code		1	I0g. Citizen of W	hat Cour	itry?
	23a or	Funeral Director	1002 H Mag	nolia Woods	Lan	e	2104	40		USA		
	ter deat Items 2	Inera	11. Marital Status	12. Was Decedent Armed Forces		6. 13.	Was Decedent of H	Hispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No- Rican, etc.)		· Americ	an Indian, etc.
36	within 72 hours after death with the Maryland sne. sne. than "nature!", or Items 23a or 28a-f ehow the Madical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☑ Mi 3 ☐ Widowed 4 ☐ Divorce	If Yes, Give	No		1⊡Yes 2√ No			Specify:	Whi	te
9-	72 hours "naturel",		15. Deced	ent's Education		16a. Dece	ient's Usual Occup	pation		16b. Kind of Bu	siness/Inc	dustry
256	ithin 7 96. Med "n	Completed	Elementary/Secondary (0-12	nest grade completed) College (1-4or	5+)		king or work gone DO NOT use retire emaker	pation during most of workir d)	ng	own h	ome	
C012	Hygier Hygier Ther th	Co	12th 17. Father's Name (First, Middle	e (ast)		1101116	maker	18. Mother's Name	(First Middle	Maiden Sumame		
/	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental aumatic event, the Mental aumatic event.	To Be	Thomas M. K						M. V		"	
a 2	should Mand Mand Mand Mand Mand Mand Mand Man	۲	19a. Informant's Name/Relatio			19b. Mailin	ng Address (Street	and Number or Rura			State, Zip	Code)
ÓΣ	s 1 and 2 should be filed within 72 hd if Health and Mental Hygiene. Item 27 is marked other than "natu other traumatic event, the Madical			endek /husb		A		gnolia Wo	_			
4/06 / 324 more, Maryland 21215-0036	permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tr.			n 3 Removal from State	1		sition (Name of natory or other pla	9/8/		20c. Location - C	-	
/tim	F 6 3		4 Donation 5 Other 21. Signature of Funeral Service		Gar		of Fait	th sess of Facility 30				
Ba C	permit. Departi Import any Inj		P. Ter	u Conn	ell			y Funera				
			23a. Part1. Enter the disease, shock, or heart failure. L	or complications that cause ist only one cause on each l	d the death	Do not ent	er the mode of dyi	ng, such as cardiac o	r respiratory arr	est,		Approximate Interval Between
	Physician	2 5	Immediate Cause (Final disease or condition resulting in death)	- Ano	XIC	. Er	rceph	alopat	hy		2	Onset and Death
80	/Medical Examiner		rosaming in assum	Due to (or as	a consequ	ence of):	2000	-1 -C	recti	-	1:	36 hours
31418		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequ	ence of):	reara.	ical inte	uch			le mours
33	executed in and ial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C								
86		aj E	roothing in doubly Last	Due to (or as	a consequ	ence ot):						
687		edicai		d								
E Š	requires thet the death certif been signed by the attending should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnanc	v		1	e of delive	
200 DE	ne dea the at thed fo	ysici	in the past 12 months? 1 ☐ Yes 2 XNo 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of de	ath 5	Other (specify)			Mon	(ri	Day Year
3	es thet thighed by	V Ph	Part II. Other significant cond	itions contributing to death t	out not resu	lting in the u	nderlying cause gr	ven in Part I.	23e. Did to	bacco use contri	bute to th	ne cause of death?
Z P	quires an sign	ed by	Dilated C	ardiomyo	patl	14, C	AD, by	pertension	n 10Y	es 2□No	3 🗌 Prob	ably 4 Unknown
eK Mital Records	as b	Completed			1				24a. Was a	in 24b. W	/ere auto	psy findings available mpletion of cause of
7 =	ate pag	Con							perfor	med? d	eath?	2 No
Sits P	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medi examiner?	Hospital: . d			Ott	26. Place of Death				
2.2	g Phys er this eral dii	n: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Inju	urv	ER/Outpatier 28b. Time o	I 3L DUA	4 Nursing Hon		ence 6 GOthe		γ)
Sign	Attending F r death. ector: After by the funer	atio	E	stigation	ly rear)	Injury		Yes 2 No				
alenc Division of	or Atterde Director in by the	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	mined 289. Place of in	jury - At ho tc. <i>(Specify</i>	me, farm, sti)	eet, factory, office	2	281. Location (S City or Town		ir or Rura	l Route Number,
X	Hospitel 14 hours a Funerel I tely filled		29a. Certifier 1 Certifi	ying Physician: To the best	of my know	vladija dagli	socurred at the fi	mia, data and ofana, a	nd dusta the d	auscini and mor	nour as st	3led
	To the Hospitel or Attend within 24 hours after death of the Eunerel Director: completely filled in by the	Medical	(Check only 2 Medic one)	al Examiner: On the basis of and manner st	of examinat	ion and/or in	vestigation, in my	opinion, death occurre	ed at the time, d	late and place, a	nd due to	the cause(s)
	Withi Comp	₹	29b. Signature and itle of conti	tier			29c. Licen:	se number	2	29d. Date signed	(Month,	Day, Year)
	12		- GIV	on who completed cause of	doath (harr	220\ //*	DC Print)	05626	10	414	12	006
	17		30. Name and address of personal Company of the Com	on who completed cause of	Land	- aho	Salocak	Dr. St	3117	eldir.	mr	21014
	Sta		31. Date filed (Month, Day, Yes		rar's Signal	ure A	ista)	1000				
	Registi	ar	SEPUE	1 (000	Ou Buch	64						

			For Amend	#19State of M	ang bag		ntgen tificat			and M	ental Hy	giene Rog. No2 (006	28452
_	sicia	n	 Decedent's Name (First, Middle, John J. Kunkel 	Last)							2. Date of De Month	Day	Year 2006	3. Time of Death O:37 /M.
	edic: mine		4a. Facility Name (If not institution, HAM! L. TON	give street and number		RSIN		-	Location of			4c. Cour	nty of Death	
Fune						last birthday) Yrs.	If Under Months		If Under:		8. Date of Bir (Month, Da	th ry, Ye <i>ar)</i>	9. Birthpl	ace (State or Foreign
Direc			Usual Residence of Decedent 10a. State 10b. County			y, Town or Lo	cation				sept.	15,193		Od. Inside City Limits
Maryla a-f ehov		tor		/A		timore		7						1X Yes 2 No
vith the		Direc	10e. Street and Number				10f. Zip					10g. Citizen o		-
leath v		era	805 McKim Stree	12. Was Deceden	Ever in U	.S. 13. V		202	spanic Orio	gin? (Spe	cify Yes or No Rican, etc.)		d State	
ite, Wall ylail A LL ISTOOSO s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. liem 27 s marked out the rhan "naturel", or iteme 23a or 28a-f show		by Funeral Director	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces ad 1 Tyes 2 1 If Yes, Give Year or Dates:	No	1	fYes, speo I⊡Yes		Specify:	ĭ, Puerto I	Rican, etc.)	1	lack, White, e cify: Whi	
72 ho		eted	15. Decedent's (Specify only highest	s Education grade completed)		16a. Deced	ient's Usua kind of wo	al Occupa rk done d	ition Juring mosi)	t of workir	ng	16b. Kind of	Business/Inc	lustry
filed within Hygiene.		Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		ploye)				N/A	
Mental Hyg		To Be C	17. Father's Name (First, Middle, L William Kunkel	ast)							(First, Middle nissler	, Maiden Sum	ame)	
2 should be and Mental is marked of			19a. Informant's Name/Relationshi									er, City or Tov		Code)
1 and Health em 27		-	Lawrence Kunke	el (Brother	20b. F	face of Dispo	sition (Nan	ne of			Maryl	and, 2	n - City or To	wn, State
mit. Pages partment of I portent: If its	5 6		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		EV	emetery, cren rans Fu	nera]	ther place Cha	apel C		1-06			, Maryland
permit. Pages 1 and Department of Health Importent: If Item 27	SUC.		21. Signature of Funeral Service L	1em	<u></u>	Pe 23	acefu 25 Yo	ıl Al ork F	load '.	ative Timor	nium, M	arvian	emation	n Ctr. P.A.
ate be executed This invariant control in the principle control in the	cal ner	Ilcai Examiner	23a. Part 1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. St. Due to (or a	PSI s a conseq IRIN s a conseq BENI	uence of): uence of): uence of):						7 (w)	117 6	Approximate Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Founer's light certificate has been signed by the eltending physician and managed the founer's law the funded intended the property law is the foundary intended to the death of the reason and the foundary intended to the property law in the foundary intended to the death of the property law in the foundary intended to the property of the foundary intended to the property of the foundary intended to the property of the foundary intended to the property of the foundary intended to the foundation intended to th	acied to use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant : 9 ☐ Unknown	2 🗆 Feta	Ideath 3□	Ectopic pa						Date of delive Month	ry Day Year
w requires that is been signed to	90 90	۾	Part II. Other significant condition				nderlying c	ause give	en in Part I.	•			_	e cause of death? ably 4 Dunknown
The law rec	ous z aña	Completed											b. Were autop prior to cor death? 1 Yes	osy findings available npletion of cause of
VICA Ician: sertifica	acior,	Be	25. Was case referred to medical examiner?	Honoital				Tome			(Check only	one)		
Physi Physi or this c	100	2	1 ☐ Yes 2 ☐ Mo 27. Manner of Death	Hospital: 1 Inpat		ER/Outpatien 28b. Time of		Othe Bc. Injury Work	4 - Nu			dence 6 C		')
Attending at death.		ation	1 Natural 5 Pending 2 Accident investig	ation	ay Year)	Injury	М		<br Yes 2 □!					
I or Att	a in by	Certification	3 ☐ Suicide 6 ☐ Could no determine	ned 286. Place of I	njury - At he etc. (Specif	ome, farm, str	eet, factor	, office		3	28f. Location (City or To		mber or Rura	l Route Number,
To the Hospital or Attending Phys within 24 hours after death. To the Funerel Director: After this commonly filled in he who funered in the who funered in the second on the funered in the second on the funered in the second of	etery tille	Medical C	29a. Certifier 1 Certifying (Check only one) 1 Medical E	Physician: To the best examiner: On the basis and manners	of examina	wledge, death tion and/or inv	occurred vestigation	at the tim , in my op	ne, date an pinion, dea	id place, a	and due to the ed at the time,	cause(s) and date and plac	manner as st e, and due to	ated. the cause(s)
To the To the To the	duo	Me	29b. Signature and title of certifier	-A 7702WD	114	PHYS	290)CIMU	License	number	(1)	20	29d. Date sig	ned (Month, i	Day, Year)
3			29b. Signature and title of certifier 30. Name and address of person v	who completed cause of	death (Iten	n 23a) (Type,	Print)	2000	7000	Arm 1	107.	307	5 0	006
9				DAL CITU	RC				<i>U</i> >	. ¥ { }	// / 1	- 170	2/1/1	. .
Reg	Stat gistra		31. Date filed (Month, Day, Year) SEP 0 8 20	32. Regis	irar s Signa	alure Assa	le .							

				1 - For State of Maryland / Department of Health a Certificate of Death		R	eg. No.	6 28453
		Physicia /Medic		1. Decedent's Name (First, Middle, Last) Un Cheol Kim	-	2. Date of Deat Month Sept.		3. Time of Death
		Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of	of Death		4c. County of D	∍ath
				Future Care Homewood Social Security Number 6 Sex 7 Age (In vrs. last birthday) If Under 1 Year ff Under		8. Date of Birth	N/A	
		Funeral Director		5. Social Security Number 218-23-4888 G. Sex 12 M 2 F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Hours 4. Wonths 8. Days 9. Hours 9. Hours 9. Hours	Min	Month, Day,	Year)	Birthplace (State or Foreign Country) uth Korea
	land	show		10a. State 10b. County 10c. City, Town or Location				10d. fnside City Limits
	Man	28a-f sho	tor	Maryland N/A Baltimore City				1 🛣 Yes 2 🗆 No
	E th	or 28a-f	Oire	10e. Street and Number 10f. Zip Code			0g. Citizen of What	
	ath w	8 23a	ral	2700 N. Charles Street 21218			United St	
Z	1215-0036 within 72 hours after death with the Maryland	r, or items	Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent of Hispanic Orient Handler of Hispanic Orient Handler of Hispanic Orient Handler of Hispanic Orient Handler of Hispanic Orient Handler of Hispanic Orient Handler of Hispanic Orient Handler of Hispanic Orient Handler of Handler of Handler of Handler of Hispanic Orient Handler of Handler o		efy Yes or No- lican, etc.)	Black, W	merican Indian, hite, etc. Korean
=	5-0036	eture El E	ted	15 Decedent's Education 16a Decedent's Usual Occupation			16b. Kind of Busine	ss/Industry
~	215 Fig. 72	Mag 2	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most life. DO NOT use retired) Line most life. The most life is the control of t	st of workin	9	None	
	S D		Соп	12 N/A Onemproyed			None	
10	Maryland	la de la	To Be	17. Father's Name (First, Middle, Last) Kim Young Ku Unkr		(First, Middle, I	Maiden Sumame)	
3	laryla 2 should	and is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number)				
=	(a)	Health item 27 other tr		Mr. Richard Kim Sr. (Son) 8808 Dearborn Driv			am, Maryl 20c.Location-City	
JU	imor			1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery, crematory or other place) Dulaney Valley Mem.	Sept	.7 , 2006	Timonium	, Maryland
3	Balti	Department of Important: if any injury or once		21. Signature of Funerat Service Licensee 22. Name and Address of Facility Peaceful Alternated Service Licensee 23. Signature of Funerat Service Licensee 23. Name and Address of Facility Peaceful Alternated Service Licensee 23. Name and Address of Facility Peaceful Alternated Service Licensee 23. Signature of Funerat Service Licensee 23. Name and Address of Facility Peaceful Alternated Service Licensee 23. Signature of Funerat Service Licensee 25. Name and Address of Facility Peaceful Alternated Service Licensee 26. Name and Address of Facility Peaceful Alternated Service Licensee 27. Name and Address of Facility Peaceful Alternated Service Licensee 28. Name and Address of Facility Peaceful Alternated Service Licensee 29. Name and Address of Facility Peaceful Alternated Service Licensee 29. Name and Address of Facility Peaceful Alternated Service Licensee 29. Name and Address of Facility Peaceful Alternated Service Licensee 29. Name and Address of Peaceful Alternated Service Licensee 29. Name and Address of Peaceful Alternated Service Licensee 29. Name and Address of Peaceful Alternated Service Licensee 29. Name and Address of Peaceful Alternated Service Licensee 29. Name and Address of Peaceful Alternated Service Licensee 29. Name and Address of Peaceful Alternated Service Licensee 29. Name and Address of Peaceful Alternated Service Licensee 29. Name and Address of Peaceful Alternated Service Licensee 29. Name and Address of Peaceful Alternated Service Licensee 29. Name and Address of Peaceful Alternated Service Licensee 29. Name and Address of Peaceful Alternated Service Licensee 29. Name and Address of Peaceful Alternated Service Licensee 29. Name and Address of Peaceful Alternated Service Licensee 29. Name and Address of Peaceful Alternated Service Licensee 29. Name and Address of Peaceful Alternated Service Licensee 29. Name and Address of Peaceful Alternated Service Licensee 29. Name and Address of Peaceful Alternated Service Licensee 29. Name and Address of Peaceful Altern	atives Timos	s Funer nium, M	al&Cremat aryland 2	ion Ctr. P.A. 1093
_	PI	hysician		23a. Part1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.	cardiac or	respiratory arr	est,	Approximate fnterval Between Onset and Death
		Medical xaminer		disease or condition resulting in death) a. Ond Stage Our Due to (or as a consequence of):	ano	Do.	50610	In deems
	9	sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	(00	- 91	seeze	197
	0, e execute	sician and burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):	_			
	876	physical the bu	dlcal	d			70	
	Box 68760,	attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetat death 3 □ Ectopic pregnancy			23d. Date of	
	P.O. B	by the att	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Other (specify)			Month	Day Year
	ds, P	igned be de	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	l.	1		e to the cause of death? Probably 4 Unknown
	ecol	as been s 2 should	ompleted			24a. Was a autops	n 24b. Were	autopsy findings available to completion of cause of
	E E	After this certificate hi funeral director, page	Com			perfor	goed death	n? ∕es 2□No
	/ita	ector,	Be	25. Was case referred to medical examiner? Hospital: Other: Other:	e of Death	(Check only or	re)	
	of of	rthis raldir	L.	1 Impatient 2 EMOutpatient 3 DOA	ursing Hom		ence 6 Other (5	pecify)
	S S	th. After	tlon	27. Manney of Death 1 Netural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 38b. ime of Injury 3b. Time of Injury			,2.,	
	Division of Vital Records,	frector Irector n by the	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	8f. Location (Si City or Town		Rural Route Number,
	Ospital	within 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date an (Check only 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, dea				
	d e	hin 24 the F	Medical	one) and manner stated.			9d. Date signed (M	
	٢	1 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		29b. Signature and title of certifier 29c. License number	050	3	ont b	2006
				30. Name and ddress of person who compfeted cause of death (Item 23a) (Type, Print)	1		,-,,,	2006
					Stra	85, 1	Baltin	re, mo 21218
		Sta Registi		31. Date filed (Month, Day, Year) SEP 0 8 2006				

			State of Maryland / Department of Health and M Per FH G859 9/08/06 JH Per FH G859 9/08/06 JH State of Death	lental Hy	giene (006	28454
	Dhysiai	an	Decedent's Name (First, Middle, Last)	2. Date of De		Year	3. Time of Death
	Physici /Media		leruko Louie	Sop	06	2006	845 PM
	Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death			rince	Cocaracs
	Funeral		5. Social Security Number on K 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bi	πn	9. Birthpla	ace (State or Foreign
	Director		10 M 22 F 179 Yrs.		1,1927		
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10	d. Inside City Limits
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	or 28s	Oirec	10e. Street and Number Magnolia C+. 10f. Zip Code		10g. Citizen	of What Count	_
	a 23a	rai	6005 Lanham, MD 20706		-	USA	Japan
	after deeth with the Marylan or Itams 23a or 28a-f ahow sminer must be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 12. Was Decedent of Hispanic Origin? (Specific Specific	Rican, etc.)	0- 14. F	łace - America Black, White, e	
0036		þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 12 Ho Specify:		Spe	oify: As	ian
50	72 hours 'natural'	Completed	15. Decedent's Education (Specify only highest grade completed) If a. Decedent's Usual Occupation (Give kind of work done during most of work) If a. DO NOT use retired.	ing	16b. Kind of	Business/Ind	ustry
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lan	should be ind Mental i marked c	ToB					
Aary	C1 00 68	1 18	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	Al Route Numb	er, City or Tov	vn, State, Zip	Code)
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Z F	0 0 ====		1 Rurial 2 Programation 3 Removal from State cemetery, crematory or other place)	2-06	Balt	-, M	D
L Oul	= 문란급		21. Signature Finery Service Licens 22. Name and Address of Facility		9411	<i>D</i>)	
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			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death)	ease			
	Examiner		Due to (or as a consequence of): MUD COLD FOR O MARIA AND	h			
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	A.			
	ecuter and -trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Ouglable Rear Fa Due to Lor is a consequence of):	sur	l		
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	eath certificate be executed attending physicien and for use as the burial-transit	edical					
Вох	th cert tendin r use	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			Date of deliver	y Day Year
О.	ne dea the at thed fo	Physician/M	in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{SNO} \) \(\text{Pregnant at time of death} \) 5 \(\text{Other (specify)} \) \(\text{Unknown} \) 9 \(\text{Unknown} \)			VIOITII I	Day 1 bal
, P.O.	res that the de signed by the a be detached f	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use c	ontribute to the	e cause of death?
rds	w requires been sign should be	ed by	Hyponatremic	10	Yes 2 No	3 ☐ Proba	ably 4 Unknown
ဝ	law re as bee 2 sho	piet	0 /	24a. Was		b. Were autop	sy lindings available
ĕ	The late has page	Completed		perf	ormed?	death?	2 No
Vita	ysician: Th is certiticate director, pag	Be	25. Was case referred to medical examiner? Hospital: 1 Yes 25 No. Other:				
ō	ding Phys h. After this funeral di	n; To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	me 5 Res 28d. Describe)
i	utending death. ctor: Afte y the fun	atlo	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No				
Division of Vital Records,	or Atterde	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)		(Street and Nu wn, State)	mber or Rural	Route Number,
۵	pital o		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place,	and due to the	cauca(a) and	manage on at	ntod.
	the Hospital or Attending Physician: The law requires that the death certif hin 24 hours atter death. the Funeral Diractor: After this certificate has been signed by the attending mpletely tilled in by the funeral director, page 2 should be detached for use a	Medical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.				
	To the Hospital or Attendi within 24 hours atter death. To the Funeral Director: A completely tilled in by the fi	Me	29b. Signature and triting of certifier 29c. License number		29d. Date sig	ned (Month, D	Dey, Year)
			The Jacel, 19 \$ 20058446		09/0	7/2	0 06
,	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		/	•	
Ĭ	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Regist		31. Date filed (Montin, Day, Fear) 32. Hegistrar's Signature				

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Kathryn S. Lawlor 8:30 Am 9 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oakcrest Village Parkville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 □ M 200 F 92 1/16/1914 Director 212-09-4726 Maryland Usual Residence of Dece 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. It was 23 or 28a-f show item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Experience raust be notified at 1 ☐ Yes 2000 Parkville Baltimore Directo MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 IISA 8800 Walther Blvd. by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes XXNo Specify: 3XXVidowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
___Public 15. Decedent's Education (Specify only highest grade completed) Television Elementary/Secondary (0-12) College (1-4or 5+) Accounting Clerk 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jeannette Henneman Alfred F. Witter ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health an Important: If item 27 Is any injury or other trau once. Richard D. Lawlor - son 2917 Pinewood Ave. Baltimore, MD 21214 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Evans Funeral Chapel 9/8 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, MD Bel 21. Signatur of Funera Service Licensee 22. Name and Address of Facility 8800 Harford Rd. Parkville, MD 21234 Evans Funeral Chapel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ASCUD **Examiner** Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause) Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contributa to tha causa of death? Part II. Othar significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Dichetes Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1_Yes 2_No 1 Ves 24 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? æ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 5 Pending 1 Yes 2 No investigation Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 058646 - Monica Mi) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Park ville Mn 21234 32. Registrar's Signature Boulevage Monias Course 31. Date filed (Month, Day, Year) State 8 2006 A MELSON SFP 0 **Hegistrar**

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	/Medic		Helene Longenecker		22, 2006	11:59 p M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea	
	,		11311 Cedar Lane Beltsville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		George's
•	Funeral Director		5. Social Security Number 357-14-0683 6. Sex 1 Months 2 F 7. Age (In yrs. last birthday) Months Days Hours Min. 7. Age (In yrs. last birthday) Months Days Hours Min.	Month, Day,		thplace (State or Foreign ountry) linois
	land		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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	r 28a	rec	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Co	ountry?
	h with	a D	11311 Cedar Lane 20705		USA	
36	72 hours after deeth with the Maryland "natural", or items 23a or 28a-f show wilcal Examinant mast be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Was Decedent Ever in U.S. Amed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify: V	
õ	2 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	unk	16b. Kind of Business	/Industry unk
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Maryland	should be marked o	To E	Louis Zimmerman Elsie S	tern		
lan	2 should and Men Ie marke aumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run	ral Route Number	City or Town, State,	Zip Code) unk
	s 1 and 3 Health item 27 other tr		Hospice of the Chesapeake			
Baltimore,	00		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☒ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
Balt	permit. Page Depertment Important: it eny injury o		21. Signature of Euneral Service icensee Ronald 9. Wade Virector State Anatomy Board Baltimore, MD 2120	655 W.	Baltimore	Street
	Physician /Medical		23a. Part Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	or respiratory arro	est, ,	Approximate Interval Between Onset and Death
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	led Isit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
ő,	ficete be executed physicien and is the burial-transit	i Examiner	resulting in death) Last C. Due to (or as a consequence of):			
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P.O. Box 6	death certii ie ettending ad for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 9 □ Unk		23d. Date of de Month	livery Day Year
	ires that the d signed by the i be detached	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1	pacco use contribute to	the cause of death?
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of Vital Records,	The ete h page	Completed		24a. Was a autops perforr	y prior to ned? death?	utopsy findings available completion of cause of
Vita	Physician: T this certificetral director, pa	Be	examiner?	th Check only on		
ot	Phys this aldi	.T	1 Inpatient 2 EP/Outpatient 3 DOA 4 Nursing H		ence 6 Other (Spe	ocify)
	ding h. After funer	tion	1 Natural 5 Pending (Month, Day Year) Injury Work?	20d. Describe no	w injury occurred	
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	Hospitel 24 hours a Funeral C	dical C	29a. Certifier (Check ords one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated one)			
<u> </u>	To the within 2 To the I	Me	29b. Signature and title of certifier 29c. License number	7 2	9d. Date signed (Mon.	th, Day, Year)
			SO 1 9	1	0/24/	UU
	4		30. Name and Adress of person who completed cause of death (Item 23a) (Type, Print) DR - IVASREEN KANCO, 7610 Carroll Ave., Takom	a Park.	MD 20912	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's-Signature.			
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			1 - For State Registrar	State of Ma		artment of H			ene 200 (5 28457
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ဖွ	or Items	Ē	1 Never Married 2 Married	Armed Forces? 1 ★ Yes 2 No		If Yes, specify Cuba 1 ☐ Yes 2√√No	Specify:	o riican, etc.)	Black, Wh	
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	and 2 selth in 27 I		Candace Smith/Gra	ndaughter	5300	Sweet Bi	irch Ct.,	Ellicott		
ore	of He		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ F	Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	:0)	Date 20	Oc. Location - City o	r Town, State
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Baltimore,	permit. Pages 1 and 2 Department of Heelth a Important: If item 27 le any Injury or other trai		21. Signature of Funeral Pervice Licens	70 /		2. Name and Addres		MMUNITY E	TUNERAL HO	OME P.A.
	005 # Q	-	(1) alla (10]	<u> 206 W NOI</u>	RTH AVENU	JE		Approximate
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u C	After Funer	on	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wor	yat k? Yes 2 ∐ No	28d. Describe how	injury occurred	
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ρi	after after Dira	ertii	4 Homicide determined	building, etc.	(Specify)	,,,		City or Town,	State)	,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification;	29a. Gertifier Certifying Phy (Check only 2 Medical Exami	nician: To the best of iner: On the basis of e	my knowladge, daar	h consirred at the tin	ne, data and place	and due to the ray	e sa mem Une (a)aar	s stated
	he Hi in 24 he Fu pletel	edic	one)	and manner state	ed.	estigation, in my o	pinion, death occu	rred at the time, dat	e and place, and du	e to the cause(s)
	with To t	Σ	29b. Signature and title of certified		D	29c. Licens			d. Date signed (Mon	*
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	51		30. Name and address of person who co		01	Print)	Na	Balti.	mar p	
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	DI		1. Decedent's Name (First, Middle, La	st)						Ī	2. Date of De				3. Time of Death
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1215-0036 Within 72 hours after death with the Maryland	n "nal	plete	(Specify only highest gra	de completed)		(Give	kind of w	ual Occupat ork done du use retired)	ion iring most	of workin	g	160. K	(ind of Busines	s/indu	stry
21215-0036 d within 72 hours af	4.4	Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4o	r 5+) 	Sale	es Re	prese	ntati	ive		Foo	od Serv	ice	S
	vent vent	Be	17. Father's Name (First, Middle, Last)					1	8. Mother	r's Name	(First, Middle	, Maiden	Sumame)		
Maryland 21215-0036 td 2 should be filed within 72 hours after death and Mantal Horisone	if format in months in the factor of them 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at	၉	James Martin							Marie			iller		
Mar nd 2 sh	7 le n traun		19a. Informant's Name/Relationship (Karen Kutrik / Da				_					-	or Town, State		·
6 1 an	tem 2 other	1	20a. Method of Disposition	augiter	20b.	Place of Dispo	sition (N	me of	Ţ		LUCKEY		lle, Md.		
Saltimore,	Important: If Item 27 is eny injury or other tra		1 🕅 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 1)		8	cemetery, cren w Cathe		. ,		9/11/	/06	Bald	timore,	Ma	rul and
Balti Permit.	Importa eny inju pnce.		21. Signature of Funeral Service Lice		1100			and Address			CG	ידטעו	1050 Y		
© & &	8 = 3		120x d.	///		Ru	ick 1	้อผลอก	Fune	eral	Home,	Inc.	.Towson	,19d	.21204
			23a. Part1. Enter the disease, or or shock, or heart failure. List in	one cause on each	ed the dea line.									A in	pproximate hterval Between
	sician	1	Immediate Cause (Final disease or condition resulting in death)	a 596		lous	cel	el c	CAY	1cer	97	The 1	mouth		moset and Death
	ledical aminer		1	Due to (or a	s a consec	quence of):					O				
	3.	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consec	quence of):									
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8760 cate be e	physic the b	dicai		d										-	
X 6	attending p for use as	Physician/Me	IF FEMALE:	23c. If yes, outcom	e of pregn	ancy							23d. Date of d	olistoot	
Box	atter d for u	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant	2 Feta	aldeath 3 ☐	Ectopic Other (s	pregnancy					Month Month	Da	ay Year
P.O.	detached	hys	9 Unknown	9☐ Unknown							1				
	P 60	by P	Part II. Other significant conditions of	ontributing to death	but not res	sulting in the ur	nderlying	cause given	in Part I.						cause of death?
Records,	should	Completed									10	Yes 2			ly 4 □Unknown
Sec B law	has b je 2 sl	nple									24a. Was autoj		24b. Were a	autopsy comp	y findings available letion of cause of
	certificete has t irector, page 2 s		25.14								1 Yes	2 No	1 Ye	s 2[□ No
Vit	s certi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpa	ient 2] ER/Outpatien	t 3 🗆 🗅	Othor			(Check only o		6 ØOther (Sp		11
o c	er this		27. Manner of Death	28a. Date of In (Month, D		28b. Time of		28c. Injury a Work?	nt		Bd. Describe			ecity)	Tospice
sior endin	or: Aft	atio	1 Natural 5 Pending 2 Accident investigation	1	ay roar,	Injury	М		s 2 🗆 N	10					
Division of Vital Ior Attending Physician:	lrect n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	280. Place of I	njury - At h etc. <i>(Speci</i>	nome, farm, str	eet, facto	ry, office		2	8f. Location (City or To	Street an wn, State	nd Number or F a)	Rural A	loute Number,
pital	eral C		29a. Certifier 1 Certifying Ph	ysician: To the bes	4 -4 1			d a de la companya de la companya de la companya de la companya de la companya de la companya de la companya de	4-1	4 -1					
Division of Vital To the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only one)	niner: On the basis and manner:	of examina	ation and/or inv	estigatio	n, in my opir	, date and nion, death	h occurre	d at the time,	date and) and manner a d place, and du	s state	ed. e cause(s)
To the	To the	Me	29b. Signature and title of certifier	1-0			25	c. License r	number			29d. Da	te signed (Mor	nth, Da	y, Year)
			M Buthon	willey	, in	0	1	125	205		3	sepy	tenber	7	2006
12	+1		30. Name and address of person who									1	-		
15	,		W.A. Riley GBMC	6701 N.	Char trar's Sign	les St.	; Ba	ltimor	^e, M	ID 21	204				
	Sta Registr			006	ina s sign	JE A	TEAR.	2							

			For	State of I			nt of Health		•	•	.
			1 - State Registrar			Certifica	ite of Death	h	Re	g. No. 200	6 28459
	Physici	an	Decedent's Name (First, Mid					2	. Date of Death Month	Day Ye	3. Time of Death
	/Medi	cal	Sertsri 4a. Facility Name (If not instituti	Mehen	orl .	4h Cit	y, Town, or Location	of Dooth	09-	06-00	
	Examir	ıer	Franklin Squar	, , , ,	Con Lor		osedale	1 or Death		Ro 14	more
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last bi	irthday) If Und	er i Year II Unde	or 24 Hrs. 8	. Date of Birth	() () () () () () () () () ()	Birthplace (State or Foreign Country)
	Director		576-64-3150	1 □ M 2 🔀 F	71	Yrs. Month	s Days Hours	Min.	Date of Birth (Month, Day, Aug. 1,	1935	Thailand
	land		Usual Residence of Decedent 10a. State 10b. Coun	ty	10c. City, Tov	vn or Location					10d. Inside City Limits
	Mary -feh	to	MD Bal	timore	Ess	sex					1 ☐ Yes 2X No
	death with the Maryland ms 23a or 28e-f ehow finuat be notified at	Director	10e. Street and Number			10f. 2	Zip Code		10	g. Citizen of What	Country?
	ath w	rai	605 China				21221			USA	
· ~	items	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	12. Was Decede Armed Force	s?	13. Was Dec	edent of Hispanic O pecify Cuban, Mexica	origin? (Specif an, Puerto Ric	fy Yes or No- can, etc.)		merican Indian, Ihite, etc.
7+SF	ours al	Š	3 ☐¥Vidowed 4 ☐ Divorce	If Yes, Give	s:	1 ☐ Yes	2 No Specify	y:		Specify: 1	Asian
Sects	be filed within 72 hours after death with the Marylan tall Hygiene. Id other than "naturel; or items 23a or 28e-f show event, the Macical Examinar must be notified at	Completed	15. Decede (Specify only high	ent's Education nest grade completed)	16a	. Decedent's Us (Give kind of v	sual Occupation work done during mo use retired)	ost of working	11	6b. Kind of Busine	ss/Industry
25	within sne. then	mpi	Elementary/Secondary (0-12	College (1-4d	or 5+)	Homem				own hom	10
0 0	Hygin other	Be Co	12th 17. Father's Name (First, Middle	e, Last)				her's Name (F		aiden Sumame)	
) e	should be filed withir Id Mental Hygiene. marked other then imatic event, the Ms	To B	Tan Kardma:	i			Ro	od Mal	kkuncs	on	
Mehen,	2 2 2		19a. Informant's Name/Relation				ss (Street and Numb				
	1 and 1 Health tem 27		Yooravat Ka	ardmai /so	The second second	of Disposition (N	rin Cour	rt Ba.	-	e MD 21 Oc. Location - City	236
Baltimore	permit. Pages 1 and Department of Health Important: If Item 27 eny injury or other tr onges.		1 ⊠Burial 2 □ Cremation 4 □ Donation 5 □ Other		cemete	iry, crematory or ison F	other place)	9/11/	100		Mills MD
=	permit. P Departm Importar eny injur		21. Signature of Funeral Service		0.0	22. Name	and Address of Facil			Ave.Bal	
<u> </u>	88558		K. Ter	M Com	nelly	Conr	nelly Fu	neral	Home	of Esse	ex 21221
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that caus st only one cause on each	sed the death.	not enter the mo	ode of dying, such as	s cardiac or re	espiratory arres	t,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Myo.	cardial	Info	arction				4 hours
	Examiner			Due te/(or a	as a consequence	or): Heart	Failing				2 2015
	بجب	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequence	/	ranuse				- xuays
	ecutec Ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	С.							
760.	e be executed sicien and burial-transit	cai Ex	resulting in death, cast	Due to (or a	as a consequence	of):					
687	<u> </u>			d							
X	eath certificate ettending phy I for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy 2 ☐ Fetal death	205				23d. Date of	delivery
B	e deat he ett	sicie	in the past 12 months? 1 Yes 2 No		at time of death	1 3 □Ectopic 5 □ Other (s				Month	Day Year
9	thet the de ed by the detached	Phy	9 ☐ Unknown Part II. Dther significant condi			n the underlying	Lagues divas in Bart	1	220 Did toba	ann una namtaibuta	to the cause of death?
Ġ.	uires the signed Id be del	Completed by	anonic, er	rcephalos	/	70agu			1 ☐ Yes		Probably 4 Unknown
Ō	aw requir is been s 2 should	ojete	Cardia auto	nonary ar	rest. PH		7	, —	24a. Was an	24b. Were	autopsy findings available
Be	The lav	mo	throm bocy	tosis atri	. 6.,	rillati	^^		autopsy performe 1 ☐ Yes 25	prior death	o completion of cause of
/ital	sicien: Th certificete rector, pag	BeC	25. Was case referred to medic examiner?	al ATT	WI TIU	1110		e of Death (C	Check only one)	101	65 2 140
of \	Physic this co	၉	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpa		·				ce 6 ☐Other (S	Decify)
o u	ding F h. After funer	tion	1 Natural 5 ☐ Pend	ling 28a. Date of Ir (Month, Litigation		Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐		I. Describe how	injury occurred	
Division of Vital Becords. P.O. Box 68	Atten r deal ector by the	Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of	Injury - At home, fa	arm, street, facto			. Location (Stre	et and Number or	Rural Route Number,
	rs efte	Cert	Tiomede	building,	etc. (Specify)				City or Town,	State)	
	To the Hospital or Attending Physicien: The law requires that the death certifical within 24 hours effor death. Within 24 hours effor death. Completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certify (Check only one)	ing Physician: To the best If Examiner: On the basis and manner	of examination ar	e, death occurre nd/or investigation	d at the time, date at on, in my opinion, de	nd place, and ath occurred	due to the cau at the time, date	se(s) and manner a and place, and c	as stated. ue to the cause(s)
	To the Youthin 2	Me	29b. Signature and title of certif		statos.	25	9c. License number		290	I. Date signed (Mo	nth, Day, Year)
	N		Dur	LW.DX	My seel	.2	D3666	3		09/6	16/2006
-	4		30. Name and address of perso	n who completed cause of							
			Dr. Stuart 31. Date filed (Month, Day, Year	1)2 2000 32 Regis	9000 Fro	INKLINS	quare Dr	rive E	altim	ore, Md.	21237
	Sta Registr		SEP	A ZUNP	Self Sand	AND COMES					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006

V	-90-10		1 - For State Registrar	State of Maryla		artment o		Reg	ene 2 0 0 6 a. No.	28461
	Physici /Medi	cal		na Elvira Mo	ntoya	1			Day Year 27, 2006	3. Time of Death 11:20 A ^M
· ·	Examir Funeral	ner	5. Social Security Number 6. Se.	ge View Driv	s. last birthday)	4b. City, Tow If Under 1 Ye Months Da		s. 8. Date of Birth		th gomery thplace (State or Foreign ourtry)
	Director		132-34-0567 Usual Residence of Decedent 10a. State 10b. County	80	Yrs. City, Town or Lo		yo riodis wii	June 4,	1926	Colombia 10d. Inside City Limits
	ir deeth with the Marylan tems 23s or 28s-f show ar ittust be notified at	Director	Maryland Mont	gomery		10f. Zip Cod	Wheaton	100	j. Citizen of What Co	1 ☐ Yes 2 📉 No buntry?
036	72 hours after deeth with the Maryland natural; or items 23s or 28s-f show lical Evant ar must be notified at	by Funeral		ege View Driv 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of Yes, specify C	No Specify:	Specify Yes or No- into Rican, etc.)	United 14. Race - Ame Black, Whit Specify:	
21215-0	within iene. r than	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1 2		(Give	DO NOT use re	ne during most of w	orking 16	Sb. Kind of Business	
Maryland 21215-0036	should be filed ind Mental Hygi marked other umatic event, I	To Be C		emente Rodri			18. Mother's N		a Leon Ron	nero
ďΣ	l and 2 leath a im 27 is her trau		19a. Informant's Name/Relationship (Ty Clara Moore/ Dat 20a. Method of Disposition 1 ☒ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	ighter 20b.	20237 Place of Dispo		y Terrace	Date 20 ugust	antown, Mac. Location - City or	aryland 2087 Town, State
Baltıı	permit. Pages 'Department of Himportant: If Ite any injury or of once.		21. Signature of Funeral Service Licenson		335 Reave	Name and Ad Rockvi Rockvi	dress of Facility Relate, Inc.	obert A. Po 300 West 1 Land 20850	imphrey Fi Montgomery -2805	ng, Marylan ineral Home/ y Avenue
<u>`</u>	death certificate be executed Washington by sician and cor use as the burial-transit	dical Examiner	23a. Part1. Enter the disease or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. Tarry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	ardial quence of):			ac or respiratory arres		Approximate Interval Between Onset and Death 1 Day
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L	law requires that the as been signed by the 2 should be detache	þ	Part II. Other significant conditions cor	tributing to death but not re	sulfing in fhe u	nderlying cause	given in Part I.			the cause of death?
מו חמכו	The ate h page	e Completed	or W.					24a. Was an autopsy performe 1 Yes 2	prior to d	itopsy findings available completion of cause of 2 No
	or the hospital or Attending Physician: within 2 burs after death. o the Funeral Director: After this certifica ompletely filled in by the funeral director.	To B	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Ir	Other: 4 🗆 Nursing	Ath (Check only one) Home 5 X Residence 28d. Describe how		cify)
2	Hospital or Att	al Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Special ician: To the best of my kn	owledge, death	occurred at the	time date and place	City or Town, S	ac Janaem bas (2)92	stated
	within 24 hours a vital to the Funeral Completely filled	Medical	(Check only 2 Medical Examination) 29b. Signature and title of certifier	ner: On the basis of examinand manner stated.	ation and/or inv	estigation, in m	y opinion, death occ	urred at the time, date	and place, and due Date signed (Monti	to the cause(s)
15	Sta Registr		30. Name and address of person who co Barry Hecht, M.D. 31. Date filed (Month, Day, Year)		a Drive	Wheat	D19192 on, Maryl	and 20906	August 2	0, 2000

Division of Vital Records, P.O. Box 68760,

			. For	State of Maryla	ind / Department of H	lealth and Me	ntal Hygier	ne	
_			1 - State Registrar		Certificate of	Death	Reg. N	2006	28462
-	Physici /Medi	cal	1. Decedent's Name (First, Middle, La	· T.	Miotke	5	sept 1	Day 2006	3. Time of Death
	Examir Funeral Director	ner	4a. Facility Name (If not institution, given the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the pro	tage Assist	s. last birthday) Wunder 1 Year Months Days	or Location of Death Office of the Control of the	Date of Birth (Month, Day Yea	HARF (3) Pirthpl 3 (enn.)	ace (State or Foreign try)
	death with the Maryland ms 23a or 28e-1 show rms! be notified at	Irector	10a. State 10b. County Hou for 10e. Street and Number	100.0	City, Town or Location Street 10f. Zip Code	-	10g. (10 Ditizen of What Count	od. Inside City Limits 1 ☐ Yes 2 No
	after death wit or Items 23a c	y Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Amaed Forces? 1 Yes 21 No	U.S. 13. Was Decedent of Hif Yes, specify Cub.	dispanic Origin? (Specifi an, Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - America Black, White, e	
215-0036	within 72 hours after ene. than "neturel", or Ite ha Nedical Examina	Completed by	3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	Year or Dates:	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation	16b.	Kind of Business/Ind	ustry
7	should be filed within nd Mental Hygiene. marked other than umatic event. In a Me	To Be Con	17. Father's Name (First, Middle, Last,	le	Homemake	18. Mother's Name (F	irst Middle, Maide	OX NO)	Re
iore, Maryland	yes 1 and 2 of Health a of It item 27 is or other trau		19 Informant's Name/Relationship (I hamas Mint 20a. Method of Disposition 1 □ Burial 2 Decremation 3 □	Ke 30N 20b.	19b. Mailing Address (Street 3910 Cat A Place of Disposition (Name of cemetery, crematory or other plan	J DR., Ja	rettse	v or Town, State, Zip	21084
Baltimore,	permit. Pag Department: Important: eny injury o		4 □ Donation 5 □ Other (Specification of Funeral Service Light Multiple of Funeral Service Light Multiple of Service Ligh	Javrotuy	EVANS FINE	as of Facility FOR	6/06 B EST IFICH 1-Bel Ai	C3 New	port De.
	Priysician /Medical Examiner		23a. Part . Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. Due to (or as a conse	STAGE THE	ng, such as cardiate or re	spiratory arrest,		pproximate Interval Between Onset and Death Yenny
1,092	be executed ician and burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter the design of Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect.)					
.O. Box 687	death certificate e attending phy id for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3 Ectopic pregnancy	/		23d. Date of deliver Month	y Day Year
Records, P	law requires that the de as been signed by the a 2 should be detached f	by	Part II. Other significant conditions of	ontributing to death but not re	esulting in the underlying cause giv	en in Part I.		ouse contribute to the	A .
_	n: The law r ficate has be rr, page 2 sh	e Completed	OF Wassers and the region of				24a. Was an autopsy performed? 1 Yes 2	prior to com death? lo 1 \(\sum \text{Yes} \) 2	sy findings available of cause of
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	To B	25. Was case referred to medical examiner? 1 Yes 2 27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 DOA Oth	4 Nursing Home		• Kother (Specify)	CARE
Division	itel or Atter	Certification:	3 Suicide 6 Could not b 4 Homicide determined	building, etc. (Spec			City or Town, Sta	·	
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	(Check only '2 Madical Exar	ninar: On the basis of examin and manner stated.	nowledge, death occurred at the tin nation and/or investigation, in my o	pinion, death occurred a	at the time, date a	nd place, and due to	the cause(s)
	F3F8		30. Name and address of person who	Completed cause of death (Ite	7	35889	5.	pt. 5,	2006
			ALFAAD. 31. Date filed (Month, Day, Year)	SPAMUS Banistrar's Sine	615 W. MACI	Hp.1 Ru	-1 sin	MD 2	1014
	Sta Registi	W.	SED 0 8 201)6 Jane 1	J. M.				

			1 - For Stata Registrar	State of Maryla			of Health of Death			giene Reg. No.	006	28463
	Physici	an	1. Decedent's Name (First, Middle, La	ast)					2. Date of Dea Month	ath Day	Year	3. Time of Death
do	/Medi	al	JUNIUS		MYER.			15.00	SEPTEMB	-		1330 p M
	Examir	er	4a. Facility Name (If not institution, gi				own, or Location			4c. (County of Death	
	Funeral				s. last birthday)	If Under 1		r 24 Hrs.	8. Date of Birt	h Vanal	BALTIM 9. Birth	place (State or Foreign
	Director		218-62-4954	1PM 20 F 5/	Yrs.	Months	Days Hours	Min.	Month, Day 5 - 20 -	- 195	-5 Ma	ry and
	pue **		Usual Residence of Decedent 10a, State 10b, County	10c. C	ity. Town or Lo	cation						10d. Inside City Limits
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Itam 27 is marked other then "natural", or itame 23s or 28s-f show other traumatic event, the Madical Examiner must be invitilled at	Director	Ud. Balt	imore Ro	ando	1137	lown					1 ☐ Yes 2 ♠No
	th with the 23a or 2	ai Dire	3415 Barr	y Paul R	Jun 203	10f. Zip C	.1133			10g. Citiz	ten of What Cou	intry?
	tame	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decede f Yes, specif	ent of Hispanic Or fy Cuban, Mexica	rigin? (Spec	cify Yes or No-	- 1	4. Race - Amen Black, White	ican Indian,
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ ¥es 2 □ No If Yes, Give Year or Dates:		1 □ Yes 2					- 72 i	ack.
5-0036	2 hou	ted	15. Decedent's E	Education	16a. Deced	dent's Usual	Occupation			16b. Kin	nd of Business/Ir	ndustry
215	within 72 ene. then "n	Completed	(Specify only highest gi	rade completed) College (1-4or 5+)	(Give	kind of work DO NOT use	done during mos retired)	st of workin	g		c /	/
2	filed with Hygiene other the	Con	12			abor					Stre!	
Maryland	d be til	Be	17. Father's Name (First, Middle, Las	t)			18. Moth	er's Name	(First, Middle,		,	
Z	and Men le marke	၉	19a. Informant's Name/Relationship	pe, Print)	19b. Mailin	ng Address (Street and Numb	er or Rural		r. City or		p Code)
Ma	and 2: ealth at m 27 le		Junius Myer	SON TILL SON	3111	Oak	Cford	Ave	Ba	lto.	1.0	2/2/5-
ore	00		20a. Method of Disposition 1 Burial 2 Cremation 3		Place of Dispo	sition (Name	e of ner place)	Da	ate	20c. Loc	cation - City or T	own, State
Baltimore	permit. Pages Department of Important: If It eny injury or o		4 ☐ Donation 5 ☐ Other (Spec	ity)	reenmi		remetery	9-12.	-2004	Pa	allo. L	rel.
Bal	permit. Pag Department Important: I eny injury o		21. Sign and Funeral Service Lice	C. Daufa	an e	Name and	Address of action	angle &	t. Ba	ldis	ness,	vice 1.4
п			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the dea y one cause on each line.	ath. Do not ent	er the mode	of dying, such as	s cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Nesp	inatory	- fre	eluni"					havis
	Examiner			Due to (or as a con'se		0	•					
		Jer	Sequentially list conditions, 1 ary, leading to immodate cause. Enter Underlying Cause (Disease or injury	b. Due to forms a gonse	cush e of):	pne	Mone					days
28-	icuted nd transit	Examin	that initiated events	C								
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687	physicate to the the the the the the the the the the	dice		d								
Box (eath certific ettending p	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr						2	3d. Date of deliv	rerv
ĕ	death e ette	Physician/Medical	in the past 12 months?	1 Live birth 2 Fet 4 Pregnant at time of		Ectopic pred Other <i>(spec</i>				7	Month	Day Year
P.O.	of the de d by the etached	Phys	9 Unknown	9∐ Unknown								
ecords,	The law requires that the death certificate be executed tie has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions	contributing to death but not re	sulting in the ur	nderlying cau	use given in Part I	l.				the cause of death? bably 4 Aunknown
သူ	law requas been 2 should	Completed							24a. Was a		24b. Were auto	opsy findings available ompletion of cause of
		Com							perfor	med?	death?	2Æ€No
Vital R	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Unamital:			T -	e of Death	Check only or	ne)		
of	Phys this ral di	<u>۲</u>	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2	ER/Outpatien				e 5 🗆 Resid		Other (Special	fy)
	Attending Phyrdeath.	tlon	1 (25Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	м 200	c. Injury at Work? 1 □ Yes 2 □	1	od. Describe n	OW Injury	occurred	
Division	or Attendi after death. Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	De Diese of leight At I	home, farm, stre home, farm, stre	eet, factory,			8f. Location (S City or Tow	treet and n, State)	Number or Run	al Route Number,
۵	To the Hospital or Atte within 24 hours after de To the Funerel Directo completely filled in by th		29a. Certifier 1区 Certifying P	hysician: To the best of my kn	nowledge, death	occurred at	t the time, date an	nd place, ar	nd due to the d	ause(s) a	and manner as s	stated.
	To the Hospital within 24 hours and the Funerel completely filled	edical	(Check only 2 Medical Exa	minar: On the basis of examin and manner stated.	ation and/or inv	estigation, in	n my opinion, dea	ath occurre	d at the time, o	date and p	place, and due t	o the cause(s)
	To T To T	Σ	29b. Signature and title of certifier			29c.	License number		à	29d. Date	signed (Month.	Day, Year)
			Obuton	_ mo			D0059	136		Aye	lenker.	5, 2006
	2		30. Name and address of person who				HOSPITAL		5401	Λ	Cano	ET RUAD
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature	well	MINE		7701	010		
-4	Registr		SEP 0 8 2	106 Jan John J	is la							

Physician Medical Julia Emmaline Cozaet Mason 08	of Death Day Year 3. Time of Death 1:03 P M
/Medical Julia Emmaline Ozact / Wash Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	31 2006 1:03 F M 4c. County of Death
Future Care Nursing Home Baltimore City	N A
Funeral Director 5. Social Security Number 6. Sex 1 Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 1 M 2 M F 7. Age (In yrs. last birthday) 8. Date (Months Days Hours Min. 9. Sex 1 Months Days Min. 9. Sex 1 Months Days Min. 9. Sex 1 Months Days	of Birth h, Day, Year) 12011916 9. Birthplace (State or Foreign Country)
	10d. Inside City Limits
The second of th	1⊠Yes 2 No
106. Street and Number	10g. Citizen of What Country?
11. Marrial Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married	or No- 14. Race - American Indian,
Amed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married 1 Yes, 287 No If Yes, 287 No If Yes, Give 1 Yes 287 No Specify:	Constitution
10a. State 10b. County 10c. City, Town or Location Comparison Com	16b. Kind of Business/Industry
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) 12. TH. GRADE 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	Tob. Ailid of Business/Industry
Elementary/Secondary (0·12) College (1·4or 5+) Veak Merchant 18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	Retail
Thomas Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Name) 19b. Mailing Address (Street and Number or Rural Route Name)	1
Panie Tall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route N	
Serve I Editionate Consideration Confidence and Con	Charbite NC 25273
1 PRurial 2 Cremation 3 Permoval from State	20c. Location - City or Town, State
	6 Crownerille, MD
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaugh C Greene Fune 5151 Palto Watt Pite	Baltimore, MD 21229
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat shock, or heart failure. List only one cause on each line.	ory arrest, Approximate Interval Between
Physician (Medical Cause (Final disease or condition resulting in death) Physician (Medical Cause (Final disease or condition resulting in death)	Onset and Death
Examiner Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	
Due to (or as a consequence of): a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
pen page of a specific plane of the control of the	
And the control of th	
Sign of the part o	23d. Date of delivery Month Day Year
YOU THE POLY TO THE POLY TO THE POLY TH	
	Did tobacco use contribute to the cause of death?
Pecords, The taw requires to the taw requires to the taw requires to the taw requires to the taw requirement of t	1 Yes 2 No 3 Probably 4 Unknown
The Cord and the state of the s	Was an autopsy autopsy findings available prior to completion of cause of death?
25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 1 Yes 2 No	es 2 No 1 □ Yes 2 No
	Residence 6 Other (Specify)
27. Manner of Death 1 Dinpatient 2 EP/Outpatient 3 DOA 41/2 Nursing Home 5 Death 27. Manner of Death 1 Dinpatient 2 EP/Outpatient 3 DOA 41/2 Nursing Home 5 Death (Month, Day Year) 41/2 Nursing Home 5 Death (Month, Day Year) 41/2 Nursing Home 5 Death (Month, Day Year) 41/2 Nursing Home 5 Death 1 Dinpatient 2 DEP/Outpatient 3 DOA 41/2 Nursing Home 5 Death 1 Dinpatient 2 DEP/Outpatient 3 DOA 41/2 Nursing Home 5 Death 1 Dinpatient 2 DEP/Outpatient 3 DOA 41/2 Nursing Home 5 Death 1 Dinpatient 2 DEP/Outpatient 3 DOA 41/2 Nursing Home 5 Death 1 Dinpatient 2 DEP/Outpatient 3 DOA 41/2 Nursing Home 5 Death 28d. Description Death 41/2 Nursing Home 5 Death 1 Dinpatient 2 DEP/Outpatient 3 DOA 41/2 Nursing Home 5 Death 1 Dinpatient 2 DEP/Outpatient 3 DOA 41/2 Nursing Home 5 Death 1 Dinpatient 2 DEP/Outpatient 3 DOA 41/2 Nursing Home 5 Death 1 Dinpatient 2 DEP/Outpatient 3 DOA 41/2 Nursing Home 5 Death 28d. Description Death 41/2 Nursing Home 5 Death 28d. Description Death 41/2 Nursing Home 5 Death 28d. Description Death 41/2 Nursing Home 5 Death 28d. Description Death 41/2 Nursing Home 5 Death 28d. Description Death 41/2 Nursing Home 5 Death 28d. Description Death 41/2 Nursing Home 5 Death 28d. Description Death 41/2 Nursing Home 5 Death 28d. Description Death 41/2 Nursing Home 5 Death 28d. Description Death 41/2 Nursing Home 5 Death 28d. Description Death 41/2 Nursing Home 5 Death 28d. Description Death 41/2 Nursing Home 5 Death 28d. Description Death 41/2 Nursing Home 5 Death 28d. Description Death 41/2 Nursing Home 5 Death 28d. Description Death 41/2 Nursing Home 5 Death 28d. Description Death 41/2 Nursing Home 5 Death 28d. Description Death 41/2 Nursing Home 5 Death 28d. Description Death 41/2 Nursing Home 5 Death 41/2 Nursing Home 5 Death 41/2 Nursing Home 5 Death 41/2 Nursing Home 5 Death 41/2 Nursing Home 5 Death 41/2 Nursing Home 5 Death 41/2 Nursing Home 5 Death 41/2 Nursing Home 5 Death 41/2 Nursing Home 5 Death 41/2 Nursing Home 5 Death 41/2 Nursing Home 5 Death 41/2 Nursing Hom	ribe how injury occurred
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The straight of the course of	o the cause(s) and manner as stated. ime, date and place, and due to the cause(s)
29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
Amatin H Neacem MD D15503	September 5,2006
30. Name and address of person who completed cause of death (flem 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar SEP 0 8 2006	RE MD 21217

			1 - For Amend item#2	State of perMD, ge	f Marylar 359,9/8/0	nd / Depa 6 TI <i>Cei</i>	artment of H rtificate of I	lealth and N Death	Mental Hygid Reg	ene . N 2 0 0 6	28465		
			1. Decedent's Name (First, Middle,	Last)					Date of Death Month Day Year 3. Time of Death				
	Physici /Medio		Rodney			Ma	artin		8 23 2006 2104				
	Examin		4a. Facility Name (If not institution,	give street and nu	mber)			Location of Death		4c. County of Dea	th		
			J.H. Bayview				Balti			NA			
	Funeral		5. Social Security Number 213–54–2929	5.Sex 1XДM 2☐F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1	rear) C	thplace (State or Foreign ountry)		
	Director		Usual Residence of Decedent		57_	113.			7-18-1				
	land ow		10a. State 10b. County		10c. C	ty, Town or Lo	cation				10d. Inside City Limits		
	Mary First	ţ	Md.	NA		Ral+	imore				1 XYes 2 ☐ No		
	r 28s	<u>re</u>	10e. Street and Number	147.7		שבע	10f. Zip Code		10	g. Citizen of What C	ountry?		
	th with	a D	1243 Glenwood A	Avenue			2123	39		USA			
	deal	Funeral Director	11. Marital Status		edent Ever in U		Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sr	pecify Yes or No-	14. Race - Am Black, Whi			
92	72 hours after death with the Maryland natural', or Itama 23a or 28a-f ehow dical Examinar must be notified at	5	1 Never Married 2 Marrie		2X No		1 ☐ Yes 2 ☐ X No	Specify:	Triodit, Blo.)	Specify: B			
21215-0036	ural',	d by	3 Widowed 4 Divorced	Year or D	ates:		**			Specify: B	1dCK		
5	- 2	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	lent's Usual Occup: kind of work done of DO NOT use retired	during most of work	king 16	6b. Kind of Business	/Industry		
12	within ene.	μğ	Elementary/Secondary (0-12)	College (1-4or 5+)			,		Truck Dr	iver		
9	be filed within 72 hours after death with the Marylan ital Hygiene. We other than "naturel", or Itema 23a or 28a-1 ehow event, Ite Medical Examinar ment be notified at	Ö	11th grade 17. Father's Name (First, Middle, La	ast)		La	oorer	18. Mother's Nam	ne (First, Middle, Ma		1101		
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, I'le M	To B	Luther		Martir	n		Nanni	e	Wal	ker		
ary	should ind Men ind Men in marke	_	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ig Address (Street	and Number or Ru	ral Route Number, (City or Town, State,			
	라를 2		Sandra Tapp	Si	ster	124	3 Glenwoo	d Avenue	, Baltimo	re, Md.	21239		
ore	of Head		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Demonstration	t .	Place of Dispo	sition (Name of natory or other place		Date 20	Oc. Location - City or	Town, State		
Ĕ	Pag ment ant: f ury o		4 □Donation 5 □ Other (Spe			It. Zio	n Cem.	9-	2-06	Lansdowne	, Md.		
Baltimore,	permit. Pages 1 Department of the Important: If Its any injury or ot once.		21. Signature of Funeral Service Li	censee			Name and Addres		March F.I , Baltim	H. East	21202		
			23a. Part1. Enter the disease, or c	omplications that	aused the dea						Approximate		
	Physician		shock, or heart failure. List of Immediate Cause (Final			150 3	(11)	3 110 -			Interval Between Onset and Death		
	/Medical		disease or condition resulting in death)	a. 77/172 Due to	(or as a consec	quence of):	C CARD	10VAS C	ILAR D	(36772	Syens		
	Examiner		Conventially list conditions	, EN.	0 52	AGE	RENAL	- Ans	SEASE				
	p / /=	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(ur as a consec	quence of):							
	and A	Examln	Cause (Disease or injury that initiated events resulting in death) Last	c									
58760,	ficate be executed physicien and the burial-transit	JE E	Tooling in double, East	Due to	or as a consec	quence or);							
87	physi the	dlcal	'	d.									
_	ding se as		IF FEMALE:	23c. If yes. ou	tcome of pregn	ancv				02d Date of de	F		
Вох	death certific e attending p od for use as	clar	23b. Was decedent pregnant in the past 12 months?	1□Live t	ointh 2 ☐ Feta nant at time of c	aldeath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year		
P.O.	0 0 0	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn									
	The law requires that the ste hes been signed by th bage 2 should be detache	by P	Part II. Other significant condition	s contributing to d	eath but not res	sulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute t	the cause of death?		
ğ	w require been sig should b		HYFERTE	NS/ON	/				1 ☐ Yes	2 No 3 P	robably 4 Dunknown		
000	e law requ hes been je 2 shoul	Completed							24a. Was an	24b. Were a	utopsy findings available		
ž	The I	mo;							autopsy performe	ed? death?	completion of cause of		
ita	ysician: Th is certificete director, pag	Вес	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only one)	7			
× >	S S D	2	1 ☐ Yes 2 🔁 No	Hospital: 1	Inpatient 2	ER/Outpatien	t 3🗷 DOA Othe	er: 4 🗌 Nursing Ho	ome 5 R Residen	co 6 □Other (Spe	icify)		
ū	ing P	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending		of Injury th, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe how	injury occurred			
Sio	r Attending Fer death.	cat	2 Accident investiga 3 Suicide 6 Could no	t be				Yes 2□No					
Division of Vital Records,	of or Attendated after death Director:	Certification:	4 Homicide determin	ad 250. Place	ng, etc. (Speci	ome, farm, str fy)	eet, factory, office		City or Town,	et and Number or R State)	ural Route Number,		
	spitel lours neral filled	N N	29a. Certifier 1 ☑ Certifying	Physician: To the	best of my kno	owledge, death	occurred at the tim	e, date and place	and due to the cau	se(s) and manner a	s stated		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Ex	kaminer: On the b and man	asis of examination of the stated.	ation and/or inv	estigation, in my or	pinion, death occur	red at the time, dat	ise(s) and manner a e and place, and du	e to the cause(s)		
	To the To the Comp	ž	29b. Signature and title of certifier	,			29c. License	number	290	d. Date signed (Moni	h, Day, Year)		
,	^		This of	Lando	~	171)	1)0	0357.	06 1	Luguese.	30 4 2006		
	7		30. Name and address of person w	ho completed caus	e of death (Ite	n 23a) (Type,	Print)	2	RA-		1 0		
	V		ELIAS GHAN 31. Date filed (Month, Day, Year)	you1	politicario Sino	AM ALI	Ad Hosp.	3 Notto	1)174,	MORE, M	1 2/239		
4	Sta Registr												

		1 - State Registrar			Cei	rtifica	te of L	Death		R	.g. 120	06	28466
Physicial	an	1. Decedent's Name (First, Middle, La	st)	<u> </u>						Date of Deat Month		Year	3. Time of Death
Physici /Medic		ELLEN MAE MEDI								SEPTEME	BER 4,	2006	4:59 A M
Examin	er	4a. Facility Name (If not institution, giv 184 Rowlandsvill		iber)			, Town, or	Location of	of Death		4c. Cour	ity of Deat	h
Funeral Director		227-20-1101	ex □M % □F	7. Age (In yrs	i. last birthday) Yrs.	If Unde Months	Days	If Under Hours	Min.	Apre of Both	1926 2006	Co	hplace (State or Foreig untry) ginia
¥		Usual Residence of Decedent 10a, State 10b, County		10c. C	ity, Town or Lo	ocation							10d. Inside City Limit
d aho	ō	Marvland Cecil			onowing								1 □ Yes 2 🛣 N
natural, or Items 23a or 28a-f ahow Jical Exaction Louet be notified at	rec	Maryland Cecil 10e. Street and Number			OHOWIH		p Code	· · · · · · · · · · · · · · · · · · ·		1	0g. Citizen o	f What Co	untry?
23a o	ai D	184 Rowlandsville	Rd.			21	918				USA		
"natural", or Items 23a or 28a-f ahow edical Examber Lasat ke mutifiad at	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Deced Armed For 1 Yes If Yes, Give	ces? 2.⊠No		Was Dece If Yes, spe 1 \(\text{Yes} \)	ecify Cuba	ispanic Ori n, Mexicar Specify:	gin? (Spec n, Puerto P	offy Yes or No- lican, etc.)	В	lack, White	ncan Indian, e, etc.
E E	d by	3 Widowed 4 □ Divorced	Year or Da	tes:							Spec	wh.	ite
- 19	Completed by	15. Decedent's E (Specify only highest gra			16a. Dece	kind of w	ual Occupa ork done d use retired	ation during mos	t of workin	ng	16b. Kind of	Business/	Industry
than	дшо	Elementary/Secondary (0-12)	College (1-	4or 5+)	Cook		ise retired	,			Dubli	c Edu	cation
ther it.	a	17. Father's Name (First, Middle, Last)		COOR			18. Mothe	er's Name	(First, Middle, M			cacion
ked c	To B	Elbert Price Houd	ck					Flor	ence	Alberta	Good	pastu	re
2 - 2	_	19a. Informant's Name/Relationship (Туре, Print)		19b. Maifir	ng Addres	s (Street a	and Numbe	er or Rural	Route Number	City or Tow	n, State, Z	ip Code)
n 27 l		Carlotta Crouse/ I	aughter		184.1	owla	ndsvi	ille	Rd	Conowir	go. M	arvla	nd 21918
nent of He Int: If Itan Iry or oth		20a. Method of Disposition 1 Disposition 2 Cremation 3	J		Place of Dispo cemetery, cres	sition /Na	me of	1	Da	ate	20c. Location	n - City or	Town, State
ant: I		4 Donation 5 Other (Special		Be	l Air M	1emor	ial		9-8-0)6 E	Bel Ai	r, Ma	ry1and
Department of Health a Important: If Itam 27 Is any injury or other tra		21. Ston, use of Funeral Service Licer	S Polita	the						e, P. A		arvl a	nd 21009
		23a. Part1. Enter the disease, or com shock, of heart failure. List only	plications that ca	used the dea	th. Do not ent	er the mo	de of dying	g, such as	cardiac or	respiratory arre	est,	агута	Approximate Interval Between
ysician		Immediate Cause (Final disease or condition	, Lu	. (ancer								Onset and Death
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physician and s the burial-transit	alE		, 										
	edical		_ 0.							1.700-0-0-0			
attending p for use as	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc			Je					23d. C	ate of deli	very
	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		th 2∏Fet int at time of win		Ectopic p Other (s					h	Month	Day Year
ed by the detached	Ph	Part II. Other significant conditions of	ontributing to dea	ath but not re	sulting in the u	nderlyina (cause give	an in Part I		23e. Did tob	acco use co	ntribute to	the cause of death?
signed t	d by	the ponten so	~		•	,					s 2 No		obably 4 Unknown
been s	Completed		3-0					-		24a. Was a	241	More au	tancy findings available
has le 2	dmo									autops perform	y	prior to death?	topsy findings available completion of cause of
certificate rector, pag		25. Was case referred to medical						00 DI	-40	1 ☐ Yes 2	No	1 🗆 Yes	2□ No
After this certific funeral director,	To Be	examiner?	Hospital:	patient 2	☐ ER/Outpatien	nt 3 D	OA Othe	\r.		e 5 ½ Reside		thor (Spec	26.1
ter thi		27. Manner of Death	28a. Date of		28b. Time of		28c. Injury Work			8d. Describe ho			ary)
ctor: Aft y the fun	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		, Day rear)	Injury	М		Yes 2	No				
rector: by the	Certification:	3 Suicide 6 Could not b	286. Place 0	of Injury - At I	nome, farm, str	eet, factor	y, office		28	8f. Location (Sti City or Town		nber or Ru	ral Route Number,
el Dire			1										
To the Funeral Director: completely filled in by the	Medicai	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exar	ysician: To the t niner: On the bas and manne	sis of examin	owledge, death ation and/or inv	n occurred vestigation	at the time n, in my op	ie, date an pinion, dea	d place, ar th occurre	nd due to the ca d at the time, da	use(s) and rate and place	manner as e, and due	stated. to the cause(s)
within 24 nours To the Funerel completely filled	Me	29b. Signature and title of certifier				29	c. License	number		25	d. Date sign	ned (Month	n, Day, Year)
0		Sanda 12	. Went	m	cm &		DOG	443	13		09/0	6/20	06
1 1		- IN IN		44. A					-	F	_ , ,		
HI		30. Name an person who	completed cause	of death	23a) (Type.	Print)					. (1	
H		30. Name an oress of person who Joseph K. Weidne			23а) (Туре,		Mass	Pic	ing 9	Sun, MD	21011	1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes and All Copies Are Legible.

		ľ	1 - For State Registrar	State of M	laryland / Depa	artment of F rtificate of	Death	ental Hygie Reg	2006	28467	
	Physici		1. Decedent's Name (First, Middle, Marilyn M. N	Last) Owak				2. Date of Death Month Sontombol	Day Year 3, 2006	3. Time of Death	
	/Medio Examin		4a. Fecility Name (If not institution,	give street and number)		or Location of Death	Gereamo	4c. County of Deat	h	
	F		5103 Page Lane 5. Social Security Number		ge (In yrs. last birthday)	If Under 1 Year	River If Under 24 Hrs.	8. Date of Birth		3. Time of Death 7:58 A M County of Death INE ATUNDER 9. Birthplace (State or Foreign New York 10d. Inside City Limits 12 Yes 2 No zen of What Country? I.S.A. 14. Race - American Indian, Black, White, etc. Specify: White Ind of Business/Industry Mentary School Sumame) So Town, State, Zip Code) 10011 cation - City or Town, State andria, VA ral Homes D 21236 Approximate Interval Between Onset and Death III Moss 13d. Date of delivery Month Day Year 13d. Date of delivery Month Day Year 13d. Date of delivery Month Day Year 13d. Date of delivery Month Day Year 13d. Date of delivery Month Day Year 13d. Date of delivery Month Day Year 13d. Date of delivery Month Day Year 13d. Date of delivery Month Day Year 13d. Date of delivery Month Day Year 13d. Date of delivery Month Day Year 13d. Date of delivery Month Day Year 13d. Date of delivery Month Day Year 13d. Date of delivery Month Day Year 13d. Date of delivery Month Day Year 13d. Other (Specify) Residence Moumber or Rural Route Number. 14d. Number or Rural Route Number.	
	Funeral Director		074-40-2574	1□M 20(F	58 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y Aug. 1,	1948 New	York	
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits	
	e Man	ctor	DC	NA	Was	shington				1∭X Yes 2 □ No	
	with the or 28	Dire	10e. Street and Number 4619 Van Ness	C+ Mu		10f. Zip Code	20016	10g	. Citizen of What Co	untry?	
98	be filed within 72 hours after death with the Maryland stal Hygiene. de other then "naturel", or iteme 23a or 28a-f ehow event, the Medical Expriner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie	12. Was Deceden Armed Forces d 1 Yes 2 2	(No		lispanic Origin? (Specan, Mexican, Puerto F	cify Yes or No- Rican, etc.)	Black, White	e, etc.	
21215-0036	2 hours	d ba	3 ☐ Widowed 4 🛣 Divorced	Year or Dates:	16a Dece	dent's Usual Occur	pation	16			
215	e = 100	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+	(Give	_	during most of workin d)	g			
	filed w Hygier ther th	Co	17. Father's Name (First, Middle, L			Teach	18. Mother's Name			School	
/lan	2 should be filed withir and Mental Hygiene. Ie marked other then aumatic event, the Me	To Be	George M. Nowa	k			Mary I	iene Tho	omas		
Maryland	d 2 sho th and I to mu		19a. Informant's Name/Relationsh Heather Dalsim			•	and Number or Rural				
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 ie marke eny injury or other traumatic once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		20b. Place of Dispo	esition (Name of matory or other place	ce) Da	ate 20	c. Location - City or	Town, State	
Itim	Pa Pa		4 □Donation 5 □ Other (Sp 21. Signature of Suneral Service L	ecify)	Metropol				,		
Ba	permit. Departm Importer eny Inju		I fletble	7			ir Rd., Bo				
	Physician		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition		ad the death. Do not ent line.			respiratory arrest		Interval Between	
1	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):	- Cian	(6, 8	Icany 1	ANTER	10 mas	
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	s a consequence of):	CLEMI	CELL U	VIIIC/ C	PIPCOR	70 7-103	
٧	and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or a:	s a consequence of):						
68760,	ificate be executed g physician and as the burial-transit	edical E	1	d							
Вох 68	E Doug		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy			23d. Date of deli	very	
P.O. B	the deat y the atte	Physician/M	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown			Other (specify)	,		Month	Day Year	
	w requires that the death cert been signed by the attendin should be detached for use	þ	Part II. Other significant condition	s contributing to death	but not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tobac			
cor	~ O 3	Completed						24a. Wasan	24b. Were au	topsy findings available	
- B	The law cate has page 2:	Com						autopsy performe 1 ☐ Yes 2 💢	d? death?		
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ient 2 ☐ ER/Outpatier	nt 3□ DOA O#	26. Place of Death		X	Sister's	
on of	ding Phy h. After this funeral d	tion: To	27. Manner of Death 1 KNatural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, D	urv 28b. Time o	28c. Injur		8d. Describe how		ny) Kestaence	
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director Atter this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not determine	of be 28e. Place of Ir	njury - At home, farm, str etc. (Specify)			8f. Location (Stree City or Town, S		ral Route Number,	
	Andread Hoopstall	Medical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the bes xaminer: On the basis and manner s	t of my knowledge, death of examination and/or in stated.	n occurred at the till vestigation, in my o	me, date and place, a opinion, death occurre	nd due to the caus d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	0 06	1 '	29c. Licens	se number	29d	. Date signed (Month	o, Day, Year)	
			▶ William		Luie es	10/0	0861		5 SEP	2006	
	12		30. Name and address of person w	MEGUIA	death (Item 23a) (Type,	103 Fre	inklin Sq	uon Pr.	Balto	n. Day, Year) 2006 MD 2123.]	
	Sta Registr	_	31. Date filed (Month, Day, Year)	27	trar's Signature	carle	8	-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydien 2000 C

			For State Registrar		State of Ma	arylanu /			te of L		iria ivie		Reg. No.	סנ	28466	
<i>A</i>	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3. Time of Decedent's Name (First, Middle, Last)											3. Time of Death		
	/Medic	al	Mary Camille Neary 4a. Facility Name (If not institution, give street and number)						4b. City, Town, or Location of Death			Sept.	4 20	006	1:35 a [™]	
30	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Executive meditied at or is any Injury or other traumatic event, the Medical Executive meditied at or is any Injury or other traumatic event, the Medical Executive meditied at or is any Injury or other traumatic event, the Medical Executive meditied at or is any Injury or other traumatic event, the Medical Executive medical Executi	er	Maria Health Care Center						Baltimore MD)	Baltimore			
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)					If Unde	If Linder 1 Year If Linder 24 Hrs o			B. Date of Birt (Month, Da)	h	Birthplace (State or Foreign Country)		
.3											ryland					
re, Maryland 21215-0036			10a. State 10b. County 10c. City, Town or Local						ation					1	Od. Inside City Limits	
		ctor	MD	e	Baltimore							1 ☐ Yes 2 XNo				
		Director	10e. Street and Num											g. Citizen of What Country?		
		Funerai	6401 N •	Charles	12. Was Decedent	Ever in U.S.	13. \	Was Deci		212 spanic Orig	gin? (Spec	ify Yes or No-	US A		can Indian,	
		þ	1 Never Marrie		Armed Forces? 1 Yes 2 Yes If Yes, Give Year or Dates:	1 Yes 2 No			Was Decedent of Hispanic Origin? (Specify Yes or N f Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes X☐ No Specify:				Black, White, etc. Specify: White			
		To Be Completed		cation completed)	nleted) 16a. Deced			dent's Usual Occupation kind of work done during most of working DO NOT use retired)			7	16b. Kind of Business/Industry				
			Elementary/Secon	+) Teacher						Parochial School						
			17. Father's Name (First, Middle, Last)					20110	18. Mother's Name (First, Middle,							
			Thomas										-	y Neary		
				me/Relationship (Ty	•			•					r, City or Town,			
			20a. Method of Dispo			20b. Place	of Dispo	sition (Na	ame of		Da Da		zimore 20c. Location -	MD City or To		
Ē			1 To Burial 2 Cremation 3 Removal from State Villa Maria Cemetery 9/7/06 Glen Arm, MD													
Baltimore,			21 Squature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility Mitchell-Wiedefeld 6500 York Rd. 21212													
· 新京 · 新	Citicate be executed /Medical Examiner as the burial-transit		23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death													
			Immediate Cause (F disease or condition resulting in death)	Final		eun		via						and the same of th		
			Due to (or as a consequence of):							- / / - '	6:					
		ner	Sequentially list con if any, leading to imr cause. Enter Under	iditions, mediate itying	a consequence (1):											
68760, 'F.		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Cc. Due to (or as a consequence of):													
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_		Aedicai	IE EEN IN E							(0/0 TE			7 10 -			
Box	The law requires that the death centate has been signed by the attendingage 2 should be detached for use	edical Certification; To Be Completed by Physician/N	1 Yes 2 No 4 Pregnant at time of death 5						Ectopic pregnancy Other (specify)				23d. Date of delivery Month Day Year			
Division of Vital Records, P.O.			9 ☐ Unknown 9☐ Unknown										phacon use contr	co use contribute to the cause of death?		
	w requires t been signe should be o		, and a significant conditions continuing to death but not resulting in the tin						Johnson Green and Facts.				1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown			
	Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certifica ely filled in by the funeral director.										autop perfo	24a. Was an autopsy performed? 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No 2				
			25. Was case referre		lospital:				Othe	ar.	- 111	Check only o				
			1 Yes 2 YA 27. Manner of Death 1 Natural 2 Accident	_	28a. Date of Inju	iry 28b	28b. Time of Injury		28c. Injury Work	y at			dence 6 Other	e 6 Other (Specify) njury occurred		
			3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injury - At home, farm, street building, etc. (Specify)			eet, facto	it, factory, office			28f. Location (Street and Number or Rural Route Number City or Town, State)			al Route Number,	
			29a. Certifier (check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											stated. o the cause(s)		
	To the I	Me	29b. Signature and title of certifier									29d. Date signed	d. Date signed (Month, Day, Year)			
,		-	· Cheenan						8F D0063180				9.	9.5.06		
	4	1	30. Name and address person who completed cause of death (Item 23a) (Type, Print) Dr. Gino Freeman, 6701 N. Charles St., 5th Floor, Baltimore MD 21204													
	Sta		31. Date filed (Month		32. Registr	ar's Signature	£ 4	Joes.	Sand							
	Registi	ar		SELAGE	100	-	0	F								

	State of Maryland / Department of Health and Mental Hygiene 1 - State Amend item#5, perFH, C860 10/6/06 TT Certificate of Death Reg. No. 2006 2846	9
	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Dea	
Physician /Medical	Irene Nortleet 09 04 06 13:13	М
Examiner	4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HUSPITAL 4b. City, Town, or Location of Death BALTIMORE 4c. County of Death WA	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Yrs. 7. Age (In yrs. last birthday) Yrs. 1 Months Days Hours Min. 1 Month, Day, Year) 10 - 16 - 1930 3. Birthplace (State or For Country) Country) Connectic	
land	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lir	nits
Mary a-f sh	Md. NA Baltimore	No
5 ifier death with the Maryland or items 23s or 28s-1 show rites armust be invitited at Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 U.S.A.	
	11. Maritat Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
D 8 3 7 9	1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: Specify: Black	
15-0 172 ha 72 ha 12 ha	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use or life) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)	
d 21215-00 (Illed within 72 ho Hygiene. Hygiene, then 'nature inth, the Medical is a Completed	Elementary/Secondary (0-12) College (1-4or 5+) Nurse Health	
ryland 212 ryland 212 nould be filed with d Mental Hygiene. marked other ther matic event, the	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidea Surname)	
arylan should be marked our marked our To Bo	19a Informapt's Name/Relationship (Type, Print) 19b. Mailing Address Street and Number or Hural Route Number, City or Town, State, Zip Code)	
	Richard Norfleethusband 5418 Radecke Ave Balt. Ud. 21206	
00	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State	
Baltime Baltime permit. Pag Department: Important: Important: Assive Indux of the page.	4 Donation 5 Other (Specify) (V22 Normal Address of Funeral Service Licensee 22. Name and Address of Funeral Service Constitution Servi	4
Baltir Beatine Departme Importan any injury page:	Carlon C. Danfaer 1701 Ha Cullon St. Balto. Md. 21217	
区	23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. Approximate Interval Between	
Physician	Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Onset and Death	
/Medical Examiner	Due to (or as a consequence of):	
ner a	Sequentiatly tist conditions, if any, leading to immediate cause. Either U due ying Cause (Disease or injury	
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20 8 90 m	d	
c 68 artifical ing phy e as th	IF FEMALE:	
Division of Vital Records, P.O. Box 6870 To the Hospital or Attending Physician: The law requires that the death certificate the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the toward or the funeral director. To Be Completed by Physician/Medical Certification: To Be Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1	
s that the property of details	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death	?
ords equire equire ould b	ACUTE RENAL FAILURE 1 Yes 2 No 3 Probably Lettinking	OWI
I Records, The law requires t cate has been signe page 2 should be o	24a. Was an autopsy findings avail prior to completion of cause death? 1 Yes 1 No 1 Yes 2 No	able of
on of Vital uding Physician: th. After this certifica funeral director, p	25. Was case referred to medical examiner? Hospitat: 1 The prince of Death (Check only one) Hospitat: 1 The prince of Death (Check only one)	
of \ physical physical physical directions of the control physical directions of the c	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	
ending sath. or: Afte he fun	2 Accident investigation M 1 Yes 2 No	
Division c test or Attending P is after death. al Director: After I ed in by the funera Certification:	3 Suicide 6 Could not be determined 28e. Place of trijury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State)	
The Hospital in 24 hours a the Funeral I piletely filled edical Cellcal	29a. Certifier (Check only one) Check only one) Check only one) (Check only one)	
To the within To the comple	29b. Signature and title of centifier 29c. License number 29d. Date signed (Month, Day, Year)	
	LUPU DR. RENU GUPTAMO RES 000 09/04/06	
2	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR RENU GUPTA, 5601 LOCH RAVEN BLVD, BALTIMORE, MD 21239	
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 1- State Amend #20a-c&22 Per FH G859 9614/106at #16 Death Rag. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 8.21 PM **Physician** 2006 41/6 Marie Pryor /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL AGNES If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Numberunk 6. Sex **Funeral** Days Months Hours 1 □ M 21 1 F 67 Director Aug 25, Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or 28a-f show rthan "natural", or itame 23a or 28a-f ehov the Nedical Examiner must be notified at 1√2 Yes 2 □ No MD Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 Aldershot Road 21229 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺNo If Yes, Give Year or Dates: or itame Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: black þ 3 ☐ Widowed 4 X Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Ò licensed practical nurse healthcare treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be file Deportment of Health and Mental Hy Important: if Item 27 is marked other any lighty or other treumatic event 90AB. 17. Father's Name (First, Middle, Last) Be John Kimbrow Vivian Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florene Cooke/sister 5719 Cedar Lane Columbia, MD 21044 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 9/12/2006 4 □Donation 5 MOther (Specify) in state Metro Crematory Baltimore, Md. 22. Name and Address of Facility Cremation Society of MD. 21. Signatur of Funeral Service Licensee Ronal d S ate Anatom 21201 21228 299 Frederick RD. Baltimore, MD onn Part1. Enter the disease or complications that caused the shock, of heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DAYS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed resulting in death) Last attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Day ŏ in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No page 2 should be detached 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hoepital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospitaf: npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Certification: To 2 ER/Outpatient 3 DOA 27. Manner of eath ate of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation Injury М 1 TYes 2 No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1년 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 19906 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON ANE. BALTIMORIE MD MD PRIYANK

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

0 8 2006

Coaste

32. Registrar's Signature

			101	partment of Health and Mental Hy ertificate of Death	/giene Reg. No2006 28472	
	Physici		1. Decedent's Name (First, Middle, Last) Doris A. Perdue	2. Date of D Month Sept.	eath Day Year 3. Time of Death 1:15рм	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
	Zamin		Riverview Nursing Center	Essex	Baltimore	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 213-20-4616 1 M 215 F 82 Yrs.	/ If Under 1 Year If Under 24 Hrs. 8. Date of Bi Months Days Hours Min. (Month, D	orth 9. Birthplace (State or Foreign Country) MAryland	
	Director		213-20-4616 1 M 2 M F 82 Yrs. Usual Residence of Decedent	Dec.	15,1923 MARYLAND	
	yland now		10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits	
	e Mar	ctor	MD Baltimore Ess	ex	1 ☐ Yes 2 🛣 No	
	ith the	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
	s 23a	eral	516 Riverside Drive 11 Marital Status 12. Was Decedent Ever in U.S. 13.	21221	USA o- 14. Race - American Indian,	
(0	r Item	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.	
8	filed within 72 hours after death with the Maryland Hygiene. sthar than "natural", or Items 23a or 28e-f show ant, the Madical Examinat must be notified at	by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: White	
5	"natu	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv.	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry	
21215-0036	withir ene. than	ошо	Elementary/Secondary (0-12) College (1-4or 5+) Home	emaker	own home	
5 2	filed t Hygi othar ant, I		17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	ə, Maiden Sumame)	
/lar	uld be Menta Irkad Iric av	To Be	Henry Snell	Marie Dould	ong	
Maryland	12 sho h and h 7 Is ma			ling Address (Street and Number or Rural Route Numb 77 Bird River Road Ba		
ė,	is 1 and 2 of Health a itam 27 is other treu		20a. Method of Disposition 20b. Place of Disp	position (Name of Date	20c. Location - City or Town, State	
ē	ages ent of nt: If i		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lat	wn Cemetery 9/7/06	Baltimore MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mentat Hygiene. Importent: If item 27 Is marked othar then "natural", or Items 23a or 28e-f show any injury or other treumetic avant, the Madical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility 300 MAC		
	<u></u>		23a. Part 1. Enter the disease, or complications that caused the death, on not en	Connelly Funeral Home		
	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	ned Demonts	Approximate Approximate Interval Between Onset and Death	
8760,	cate be executed physician and the burial-transit	dical Examiner	dical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):		
P.O. Box 6	The law requires that the death certificate has been signed by the attending planes 2 should be detached for use as t	Physician/Me		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year	
Ś	uires that signed b	by	Part II. Other significant conditions contributing to death but not resulting in the	Alan (V)	tobacco use contribute to the cause of death? Yes 2 □ No 3 □ Probably 4 ➡onknown	
Vital Record	w requir s been si should	Completed	Chronic Molnutinin	Anai 24a. Was		
Re	The lav	omo		auto perf 1 ☐ Yes	opsy prior to completion of cause of death? 2 ☑ 10 1 ☐ Yes 2 ☐ 10	
<u>ra</u>	ilcien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check only		
	Physicien: r this certifica ral director, i	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			
u C	ding F	lon	27. Manner of Death Natural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injury at Work? M 1 Yes 2 No	how injury occurred	
Division of	death death ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury, - At home, farm, s'	treet, factory, office 28f. Location	(Street and Number or Rural Route Number,	
á	s after s after al Dira	Certi	4 ☐ Homicide determined building, etc. (Specify)	City or To	own, State)	
	To the Hospital or Attending Physicien: The la within 24 hours after death. To tha Funaral Director: After this certificate has completely filled in by the funeral director, page 2	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and due to the nvestigation, in my opinion, death occurred at the time	cause(s) and manner as stated. , date and place, and due to the cause(s)	
	To the within 2 To tha comple	M	29b. Signature and title of certifier Allows M.D	29c. License number	29d. Date signed (Month, Day, Year)	
1			1 Ntwo see	D-128 727	04-00-2000	
	le		30. Name and address of person who completed cause of death (Item 23a) (Type MALIKA WASERM. 70°C)	th occurred at the time, date and place, and due to the nivestigation, in my opinion, death occurred at the time, 29c. License number D-38754 Printt CASTERN BLVD.	MD-21221.	
•••	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 8 2006 32. Registrar's Signature	Easter		

			1- For State of Maryla		artment of H			2006	28473
	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Last) Rose M. Paolino 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	2. Date of Death Month	4c. County of Death	3. Time of Death
	Funeral Director		144-10-4814 ¹□M 2€XF	rs. last birthday) 91 Yrs.	Baltin If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 6/5/191		more place (State or Foreign inty) sylvania
	death with the Maryland ms 23e or 28e-f show Irriust be notified at	ctor	Usual Residence of Decedent 10a. State	City, Town or Lo					10d. Inside City Limits 1 □ Yes 🔏 🛱 No
	th with th	ai Director	10e. Street and Number 16010 Excalibur Rd.		10f. Zip Code 2071	6	10g	Citizen of What Cou	intry?
5-0036	hours after des turel', or items al Examiner m	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Yes, Sive Year or Dates:		Was Decedent of Hilf Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto f Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
and Z1Z15- be filed within 72 stal Hygiene. event, the Medic		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired aborer	during most of working	ng	b. Kind of Business/li clothing	·
		To Be C	17. Father's Name (First, Middle, Last) Carmen DiLullo 19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street		DiPiet	iden Sumame) rantonic ity or Town, State, Zi	
поге, ма	D = 7 = 0		Michael Paolino - son	P.O	. Box 12	24 Crown	sville,	MD 2103 c. Location - City or T	Own, State
Baltimor	permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other once.		21. Signatury of the raf Service Licenses	22 E	vans Fu	ss of Facility neral Ch	apel P		NJ ord Rd. , MD 21234
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as, a dons	eath. Do not ent	HEAVE	g, such as cardiac of	LUNE		Approximate finterval Between Onset and Death
3/00/s	rate be executed thysicien and the burial-transit	lical Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a constitution of the constitution o	sequence of):			30036		
O. BOX O	death certific e attanding p ed for use as	Physician/Med	## FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. ff yes, outcome of pregnant in the past 12 ☐ Fregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv	ery Day Year
ras, r	law requires that the as been signed by th 2 should be detache	by	Part If, Other significant conditions contributing to death but not it	esulting in the u	nderlying cause give	en in Part I.	23e. Did tobac	co use contribute to	. /
Ital Heco	The la	Completed	25. Was case referred to medical				24a. Was an autopsy performed	prior to co death?	opsy findings available impfetion of cause of 2 No
10 10 10	To the Hospital or Attending Physician: within 42 thous fair death within 170 the Fureral Director. After this certified completely filled in by the funeral director, it	ation: To Be	examiner?	ER/Outpatien 28b. Time of fnjury	f 28c. Injury Work	at 2	ST. III	e 6'⊠Other (Speci injury occurred	Granddaushu Residence
DIVIS	oital or Atteurs after des	Certification:	3 Suicide 6 Could not be determined 28e. Pface of Injury - A building, etc. (Spe	ecify)		ļ	City or Town, S		
	Fo the Host within 24 ho Fo the Fund completely fi	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiner and manner stated. 29b. Signature poetities of certifier	nowledge, death ination and/or inv	h occurred at the tim vestigation, in my op 29c. License	oinion, death occurre	d at the time, date	e(s) and manner as and place, and due to Date signed (Month,	o the cause(s)
	6		30. Name and address of person who dompleted cause of death (II	tem 23a) (Type,	D00 Print) 30 (e)	347-4) mier	7 OF	1056 PUDD ST	3006
	Sta Registr		31. Date filed (Month, Day, Year) SEP () 8 2006	nature	BO	WE, M	2 30	116	

			For State Registrar	State of Mary		partment of F ertificate of			iene g. No. 2005	28474
			Decedent's Name (First, Middle, L.	ast)				2. Date of Deat	h	3. Time of Death
	Physicia		Anna Myrtle Pe	routka				Month Septembe	Day Yeer	18:02 [™]
	/Medic Examin		4a. Fecility Name (If not institution, g			4b. City, Town, o	r Location of Death	beptenio	4c. County of Death	10:02
	- Admin	٠.	Upper Chesapea	ke Medical Ce	enter	Bel Air			Harford	
	Funeral				yrs. last birtho	ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		place (State or Foreign ntry)
	Director		215-18-9919	1 ☐ M 2 [X]F	85 Yrs	Months Days	Hours Min.	July 23		
	D .		Usuel Residence of Decedent							
	nylan how		10a. State 10b. County	100	c. City, Town o	Location			1	0d. Inside City Limits
	e Ma	Director	Maryland Harford		Church	ville				1 ☐ Yes 2 🙀 No
	1 5 2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	lre.	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What Cour	ntry?
	1h wi	aic	3204 Rolling Gr	een Drive		21028			USA	
	dea dea	Funerai	11. Maritaf Status	12. Was Decedent Ever Armed Forces?	in U.S.	3. Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
9	or it	Ē	1 Never Married 2 Married			1 ☐ Yes 2√2 No	Specify:	,,	Specify:	
ĕ	irel',	d b	3 Widowed 4 Divorced	Year or Dates:					Wh	ite
مُر	within 72 hours after death with the Maryland ene. than "naturel", or Iteme 23a or 28a-f ehow the Medical Examiner must be nyillied at	Completed by	15. Decedent's (Specify only highest of		(G	ecedent's Usual Occup ive kind of work done	during most of working	ng	16b. Kind of Business/In	dustry
42	vithin han	E E	Elementary/Secondary (0-12)	Colfege (1-4or 5+)		e. DO NOT use retire	a)			
COG	led v lygie her t	ပိ	12		Hom	emaker	10 Mathada Nama	(Circ. Adiatala, A	Own Home	
OE	tal H of other	Be	17. Father's Name (First, Middle, La.				18. Mother's Name			
∞	i Mer Merke Marke	2	Walter Thomas A		T		Connie Le			
Ta la	2 sh and raum	1.7	19a. Informant's Name/Relationship		1				; City or Town, State, Zip	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once.		George Peroutka			04 Rolling sposition (Name of			rchville, M	
⊘ 5	ges 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		cemetery,	crematory or other pla		vale ,	20c. Location - City or To	own, State
	Pa men tant:		4 Donation 5 Other (Spec	Α	Hillto	o Service	Corp 9-6-	-06	Towson, Mar	yland
	ermit epar npor ny in		21. Signature of Funeral Service Lic	ensee		22. Name and Addre	uneral Hor	ne, P.A.		100
Q m	∆O = o	- 1	Munus U 6	may		<u> 131/ Coke</u>	<u>sbury Road</u>	d, Abing	don, Maryla	nd 21009
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the ty one cause on each line.	death. Do not	enter the mode of dyir	ng, such as cardiac o	r respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Acuto	Myla	cardia	Infai	cotion	1	Onset and Death
	/Medical		resulting in death)	Due to (or as a co		car or a	1			
	Examiner		Sequentially list overflows	b						
V	ם ≅	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):					
<i>′</i> U _∧	cate be executed physicien and the burial-transit	am	that initiated events	c.						
000	be execuicien and purial-trai	ĕ	resulting in death) Last	Due to (or as a co	nsequence of):					
33	physic the b	dical		d						
200	ntific ng p	Med	fF FEMALE:	3.700						
O ₀	tendi r use	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pi 1 Live birth 2		3 Ectopic pregnancy	y		23d. Date of delive Month	ery Day Year
Σ	uires that the death certifi signed by the attending d be detached for use as	by Physician/Me	1 ☐ Yes 2 ▼No	4☐Pregnant at time 9☐Unknown	of death	5 Other (specify)			Month	Day 16ai
∞	at the	Å.	9 Unknown							
≥,	gned be de	ρ	Part II. Other significant conditions	contributing to death but no	ot resulting in th	e underlying cause giv	ven in Part I.		pacco use contribute to the	
ΣŠ	w requir been si should	ed	Essentia	1 Hyper+	ensiz	<u>n</u>		1 □ Ye	s 2 No 3 Prot	ably 4 Unknown
ည္မွ	law re es be 2 sh	ple						24a. Was ar		psy findings available mpletion of cause of
Ć.	ician: The law requires that the death certificate hes been signed by the attending rector, page 2 should be detached for use as	Completed						perform	ned? death?	
₹ <u>a</u>	an:	Bec	25. Was case referred to medical				26. Place of Death		^	
*	Physician: r this certifice ral director, i	To E	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 [Inpatient	2 & ER/Outpa	itient 3 DOA Oth	ner: 4 Nursing Hor	me 5 ☐ Reside	ence 6 Other (Specif	y)
30	ding Phys After this funeral di	ä	27. Manner of Death	28a. Date of Injury (Month, Day Ye	er) 28b. Tim				w injury occurred	
120	eath. or: After the fune	aţio	1/2 Naturaf 5 ☐ Pending 2 ☐ Accident investigat		0.7		Yes 2 □No			
∑. <u>S</u>	or Attendation of the control of the color.	iţ.	3 Suicide 6 Could not	28e. Pface of Injury - building, etc. (S	At home, farm	, street, factory, office		28f. Location (Sti City or Town	reet and Number or Rura	I Route Number,
EDUCT KANA RECORDS,	s afte	Certification:	4 El Homicido	build#19, etc. (5	pacity)			City or Town	r, State)	
8	Hospitel		292 Certifier LX Certifying	Physician: To the best of m	y lindwledge, d	anth occurred at the ti	ma, date and place, t	and due to the de	tuse(s) and manner as s	tstad.
4-3	T 4 m m	Medicai	(Check only 2 Medical Ex	aminer: On the basis of exa and manner stated.	mination and/o	r investigation, in my o	opinion, death occurre	ed at the time, da	ate and place, and due to	the cause(s)
	To the within 2 To the complet	X	29b. Signature and title of certifier	1		29c. Licens	se number	25	9d. Date signed (Month,	Day, Year)
	- 1		· ()\/			DI	9503	5	EPTEMB #	D 6 2001
	7.		30. Name and address of person wh	o completed cause of death	(Item 23a) (Ty	pe, Print)	134			2
	0		Manuel La	zatio mo	810	W Stra	et Ahoi	deen	EPTEMBE MD 21	001
	Sta	te	31. Date filed (Month, Dey, Year)	32. Degistrar's	Signature	70				
	Registr	ar	SEP 0 8 2	2006 Magnes	Et.	034/19				
-	MH 17 Rev 1/20	001	JL V U	The state of the s	-	343				

ORIGINAL

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06-06493			Please	Type or Pri	nt in Black	Indelible	Ink		
Willie H. Richard	son	Sta	ate of Marylan				ital Hygiene	000	
		I- For State		Certific	ate of Deatl	7	Re	g. No. 20(16 2847
Physicia		Registrar 1. Decedent's Name (First, Middle	e,Last)				2. Date of Deat		3. Time of Death
Medical Examir		Willie H. Ric	hardson				Month August 30	Day Year 2006	0807 hrs
		4a. Facility Name (if not institutio		per)	4b. City, T	own, or Location		4c. County of Deat	1
d	н	3 West Preston Street	-	,	Baltin	ore			
7				Age (In yrs. last bi	thday) If Unde	er 1 Year If Und	ler 24Hrs. 8. Date of Birt	th(MM/DD/YYYY) 9. Bit	tholace (State or
Funeral		5. Social Security Number	i		Month:		s Min.	Forei	gn unk
Director		219-10-3126	1 X M 2 F	6	O Yrs.		Jan 23	, 1946 Co	ountry)
	Ī	Usual Residence of Decedent							10d. Inside City Limits
any		10a. State 10b. County		10c. City, Town					
show	<u>_</u>	MD		Ba	ltimore				1 X Yes 2 No
aryla	Director	10e. Street and Number			10f. Zip	Code	11	0g. Citizen of What Cou	ntry?
or 2	١	3 West Presto	n Street	#104	1	2	1201	TICA	
eath with the Maryland items 23a or 28a-f show ust be notified at once.				dent Ever in U.S.	13 Was Decede		rigin? (Specify Yes or No	USA - 14. Race - Ame	rican Indian, Black,
th w	Funeral	THE METERS OF THE PROPERTY OF	arried Armed Ford	0	If Yes, specif	y Cuban, Mexica	n, Puerto Rican, etc.)	White, etc.	
or i	교		1 Yes orced If Yes, Give Year	₂ _N µnk	1 Ves 2	X No specifi	r	Specify: bla	ck
urs after iural",	ā		of Dates:	completed) 160			e kind of work done ${ m un}$		
2 hours "natii	ed	15. Decedent's Education (Spe			during most of wo	king life. DO NO	T use retired)		and don't
6 all " 172	e	Elementary/Secondary (0-12)	College (1-4	or 5+)					
5-0036 fled within 72 hours after Hygiene. I other than "natural", the M. dival Examiner	Completed	unk	unk				To Name of Print Address	Maridan Comana)	· · · · ·
5-00 led wit Hygien other		17. Father's Name (First, Middle	Last)		u	nk 18.Moth	er's Name (First, Middle, I	Maiden Surname)	unk
2121 uld be fil Mental b marked	Be								
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the N. disal Examiner must be notified at once	ျ	19a. Informant's Name/Relations			9b. Mailing Address	(Street and No	imber or Rural Route Nur	nber, City or Town, Stat	e, Zip Code) unk
y, MD 2 and 2 shou lealth and N tem 27 is n		Baltimore City	7 Police De	ept					
nore, MD ages I and 2 sh ant of Health an it: If item 27 i		20a. Method of Disposition			of Disposition (Natatory or other place		Date	20c. Location - City of	r Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 Cremation		II State	atory or other place	,			
Baltimo permit. Page Department of Important:		4 Donation 5 X Other S		ate	22 Name and	Address of Faci	lity		
Sall ermil epar mpo		21. Signature of Funeral Service Ronald	S/Wade D:	irector			Board 655 W	. Baltimore	Street
.	N AS	23a Part I. Enter the disease, of	/ / // X/// _		IRal time	ara MD	21201		Approximate Interval
Physician		failure. List only one cause	on each line.	ised the death. Do	not enter the mode	or dying, such as	caldiac of respiratory arr	cst, snock, or near	Between Onset and
Medical	110	Immediate Cause (Final disease	a. Atherosclero	tic Cardiovaso	ular Disease				Death
Examiner		or condition resulting in death)	Due to (or as a c	consequence of):					
		Sequentially list conditions,	b						
	Jer	if any, leading to immediate		consequence of):					
	重	Cause. Enter Underlying Cause (Disease or injury that initiated	C						
sit sd	Examine	events resulting in death) Last	Due to (or as a c	consequence or):					
executed an and al - transi	ical		d						
) oe ex ician	g	UNPENDED	AMENDED						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	sician/Med	IF FEMALE:		utcome of pregnand	у			23d. Date of delive	•
687 ertific	an	23b. Was decedent pregnant in t past 12 months?	I LIVE DII		2 Fetal death		pic pregnancy	Month	Day Year
ox dath co	sici	1 Yes 2 No 9 Ur	death	int at time of	5 Other (Spe	ecify)		1	
BC e der ed fe	Phys		9 DIIKIOV				D 1 220 Did t	obacco use contribute f	a the cause of death?
P.O. es that the igned by be detach		Part II. Other significant condi	tions contributing to	death but not result	ing in the underlyin	g cause given in			
res the signe	d by	<u> </u>							obably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requiring all privations. The law requiring the breath of the reliable of the functal director, page 2 should be in by the funeral director, page 2 should be	Completed						24a. Was	an 24b. Were	autopsy findings available completion of cause of
COF law has t	둳						perfo	ormed? death?	
Rec The cate	్							2 N 1	Yes 2 No
al F an: ertifi	a a	25. Was case referred to medic examiner?		···			th (Check only one)		
Vit ysici dire	0 8	1 ✓ Yes 2 No	Hospital: 1 In	npatient 2 ER	Outpatient 3	DOA Other	Nursing Home 5	Residence 6 🗸 Oth	er: Scene
of g Pli	<u>:</u>	27. Manner of Death	28a. Date o	of Injury 28 Day,Year)	b. Time of Injury	28c. Injury at W	ork? 28d. Describe	how injury occurred	
ndin be	<u>.</u>		nding	Day, ruen,		1 Yes 2	No		
Sic Atte r der recto by th	ca		estigation 28e. Place	of Injury - At home	, farm, street, factor	y, office building,	etc. 28f. Location	(Street and Number or I	Rural Route Number, City
Vivi affe Direction	Certification:	det	uld not be ermined (Specify)	, . ,			or Town,	State)	
Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director.		4 Homicide	(-)						ertod
e 110 n 24 l e Fin	g	Check only 1 Certifying I	'hysician: To the best	t of my knowledge,	death occurred at the	e time, date and	place, and due to the cau occurred at the time, date	ise(s) and manner as st e and place, and due to	arteo. the cause(s)
To the within To the comple	Medical	Medical Ex	aminer: On the basis of and manner sta						
- 5 - 5	ž	29b. Signature and title of certif	P O C		29	lc. License numb	er	29d. Date signed (A	
		1 / hand	World	ノ		O.C.M.E.		August 30, 200	6
		30. Name and address of person	n who completed caus	e of death (Item 23)	a)			<u> </u>	
		l .	Assistant Medical	Examiner 1	11 Penn Stree	t, Baltimore.	MD 21201		
			1 22 8	gistrar's Signaty	Romallo !		_ -		
	tate		3 2006	gistrar's Signature	The state of the s				
Regis	116	SEP 0	1 5000				 		

	1	For State Registrar	State	of Maryla		artmen e <i>rtificat</i> e			and ivi	ientai			006	2847
a i a i a a	_	I. Decedent's Name (First, Middle,	Last)							2. Date of		Day	Year	3. Time of Death
sician edical		John Reynolds								Aug	. 1	27	2006	
miner	4	a. Facility Name (If not institution,	-					Location of	of Death	, , ,		4c. Cou	nty of Death	
	5	Sinci Hospit		Balti	. last birthday			If Under		8 Date o	of Birth		9 Birth	place (State or Fore
eral tor		. Social obdainy Hambol S1222	1₩ 2□ F		54 Yrs.	Months		Hours	Min.	(Month Nov	Day Y	^(өаг) .951	Cou	place (State or Foreintry) unk
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To Be Completed		19a. Informant's Name/Relationshi	ip (Type, Print)		19b. Mail	ling Address	(Street a	and Numbe	or Rura	I Route N	um <i>ber, (</i>	City or Tox	wn, State, Zij	p Code)
	1	Sinai Hospital			2	401 W	. 3.	lveda	re A	Venus	. Re	1+1me	w. W.	21215
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State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

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DOSUMU MC
32. Registrar's Signature

BALTIMORE

OF

HOSPITAL

06-06213 Carroll Rasche

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	ertificate of Death	Reg. No. 2006 2847							
Physician Medical Examine	Carroll Rasche		2 Date of Death Month Day August 19, 2006 3. Time of Death 1830 hrs							
	4a. Facility Name (if not institution, give street and number) 72 Portship Road	4b. City, Town, or Location of Death Dundalk	4c. County of Death Baltimore County							
Funeral Director	1XM 2F 5	last birthday) If Under 1 Year If Under 24Hrs. 4 Yrs. Months Days Hours Min.	8. Date of Birth (MM//DD/YYYYY) 9. Birthplace (State or unk Foreign Country)							
Maryland 28a-f show any d at once.	MD Baltimore	y, Town or Location Dundalk	10d. Inside City Limits 1 Yes 2 X No							
with the Maryland ns 23a or 28a-f sho be notified at once		10f. Zip Code 21222	10g. Citizen of What Country? USA							
r death or iter must	1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates.	U.S 13. Was Decedent of Hispanic Origin? (Spunk If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No specify: 16a. Decedent's Usual Occupation (Give kind of w.	Rican, etc.) White, etc. Specify: white							
5-0036 lied within 72 hours after the William and the state of other than "natural"; the Medical Examiner. Commissed by	Elementary/Secondary (0-12) unk College (1-4 or 5+) unk	during most of working life. DO NOT use retir	ed)							
121 Id be fi Mental I narked event,			(First, Middle, Maiden Surname) unk							
MD od 2 sho tlth and m 27 is aumati	O.C.M.E. 20a. Method of Disposition 20b	111 Penn Street Ba. D. Place of Disposition (Name of cemetery,								
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Vother Specify in State 21. Signature Funeral Service Licensee Renald S. Waar, Directo	22. Name and Address of Facility State Anatomy Board	d 655 W. Baltimore Street							
M ឧក្ខំ មិនិ Physician /Medical	Baltimore, MD 21201 23a. Part I. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart follows: List only one cause on each line.									
Examiner	Immediate Cause (Final disease or condition resulting in death) Acute pneumonia Due to (or as a consequence) Sequentially list conditions,		Death							
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Ox 6876 eath certifica. attending ph for use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of prediction in the past 12 months? 23d. If yes,	egnancy 2 Fetal death 3 Ectopic pregna	23d. Date of delivery							
P.O. B rres that the designed by the be detached in the bed by the bed by the bed by the bed by by	Muccarditis: cocaine use	t resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown							
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ician: The certificate rector, page	25. Was case referred to medical examiner?	26 Place of Death (Check of De								
1 of Vi	27 Manner of Death	28b. Time of Injury 28c. Injury at Work?	g Home 5 Residence 6 Other: Scene 28d. Describe how injury occurred							
Division of Vital Records, P.O. spital or Attending Physician: The law requires that the neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detacontification: To Be Completed by E.	Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To the Hospi within 24 hour To the Funer completely fill	Check only 1 Certifying Physician: To the best of my knowledge	edge, death occurred at the time, date and place, and a and/or investigation, in my opinion, death occurred a								
	Aplina Brasself M.D.	29c License number O.C.M.E.	29d Date signed (Month, Day, Year) August 20, 2006							
	30. Name and address of person who completed cause of death (Ite Melissa Brassell, MD Assistant Medical Exam	, ,	21201							
Stat Registra	te 31. Date filed (Month, Day, Year) 32 Registrar's Signa									

			1 - For State Registrar	State of Maryla		artment o		nd Mental H	ygiene	6 28478
	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Last Arlene	Rollison		4b. City, Tow	n, or Location of			
5	Funeral Director		Franlin Square Hos 5. Social Security Number 6. Se 212–26–322		s. last birthday) Yrs.	Roseda If Under 1 Ye Months Da	ear If Under 2	8. Date of E (Month, L	Baltimo Day, Year) 1929 I	ore Birthplace (State or Foreign Country) Maryland
	he Maryland 28a-f show calified at	Director	10a. State 10b. County Maryland Baltimor 10e. Street and Number		ity, Town or Lo	liver				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
036	n 72 hours after death with the Maryland "neturel", or Hems 23s or 28s-f show adical Examiner must be notified at	by Funeral	2203 Vailthorn Roa 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 20 No If Yes, Give Year or Dates:		10f. Zip Cod 2122 Was Decedent If Yes, specify C	20 of Hispanic Orig Cuban, Mexican,	in? (Specif y Yes or N Puerto Rican, etc.)	U. S. A. II. Black, V. Specify:	American Indian, White, etc.
nd 21215-0036	filed within Hygiene. other then "	Be Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Last)	cation e <i>completed)</i> Colfege (1-4or 5+)	(Give	DO NOT use re	one during most stired)	of working 's Name (First, Middi	Sears, Ro Company (e. Maiden Sumame)	•
Maryland	d 2 should th and Men 7 le marke traumatic	ToB	19a. Informant's Name/Relationship (T)	hler 1700, Print) Daughter)		ng Address (Str		or Rural Route Num	ss ber, City or Town, Sta	
Baltimore,	Pages 1 a nent of Hea ant: If Item ury or othe		20a. Method of Disposition N Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	20b. Removal from State	Place of Dispo cemetery, crei rdens o	sition (Name of matory or other) f Faith	f place)	Date 9/9 2006	20c. Location - City	
Bal	Departi Departi Importi eny inji	-(21. Signature of Funeral Service Licens 23á. Part 1. Enter the disease, or complete shock, or heart failure. List only o	ications that caused the dea	B	ruzdzin 407 old		eral Home n Avenue		ryland 21221 Approximate Interval Between
8760,	Physician //Medical Examiner the pnual-transit th	Ical Examiner	Immediate (ause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection of	quence of):	ry	arre	ny di	islaye_	Onset and Death
P.O. Box 68	death certific e attending p d for use as	Physician/Medi	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ◯ No 9 □ Unknown	3c. ff yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	eldeath 3[Ectopic pregna			23d. Date of Month	delivery Day Year
	v requires been sign should be	Completed by Pr	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	nderlying cause		1-€07 e 1□	Yes 2 No 3 san 24b. Were	e to the cause of death? Probably 4 _Unknown a autopsy findings available
ital Re		Be Com	25. Was case referred to medical examiner?				26. Place	aute per 1 □ Yes of Death Check only	formed? death	
Division of Vital Records,	ding Phys n. After this funeral dii	Certification; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of fnjury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. lr	njury at Work? 1 □ Yes 2 □ N	28d. Describe	sidence 6 Other (5 how injury occurred	Specify)
Dİ	Hoepital or At 24 hours after d Funers! Direct tely filled in by	Certifi	4 Homicide determined	28e. Place of fnjury - At I building, etc. (Spec	ify)	_		City or To	(Street and Number of own, State)	
	To the Hoepital or Attending within 24 hours after death. To the Funers! Director: After completely filled in by the fune.	Medical	(Check only one) 29b. Signature and title of certifier	sician: To the best of my kn ner: On the basis of examin and manner stated.	ation and/or in	vestigation, in m	e time, date and ny opinion, death ense number	place, and due to the occurred at the time	e cause(s) and manne , date and place, and 29d. Date signed (M	due to the cause(s)
•	[e]		30. Name and address of person who co	empleted cause of death (Ite	om 23a) (Type,	Print) S	\$52 \$127	379	9/6	ND4
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 8 20	32. Registrar's Sign	nature	any v	11/2	11) 413	71	

			. For	State of Maryland	d / Department of He Certificate of D	alth and Mental H	ygiene	00170
			1 - State Registrar		Certificate of D			
×	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) Arnold Albe 4a. Facility Name (If not institution, give s	irt Rasna	4b. City, Town, or Li		Day Year Day Year Day Year Ac. County of Dea	3. Time of Death
	Funeral		Baltimore 5. Social Security Number 6. Sex	VA Medica	Center Bal- ast birthday) If Under 1 Year	HMOVE If Under 24 Hrs. 8. Date of B	N/A	thplace (State or Foreign
	Director		224-20-4659 Usual Residence of Decedent	IM 2□F 83	Yrs. Months Days	Hours Min. (Month, I. Nov. 1	0, 1922 V	irginia
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28e-f ehow eny injury or other treumatic event, the Medical Examinar must be notified at once.	Director	10a. State 10b. County Maryland Baltis		r, Town or Location Baltimore			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the		10e. Street and Number		10f. Zip Code	1237	10g. Citizen of What C	
	death ms 23	nera	7602 Wilhelm Avenu	12. Was Decedent Ever in U.		Danic Origin? (Specify Yes or N Mexican, Puerto Rican, etc.)	U. S	erican Indian,
980	ours after ral', or ite	by Funerai	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 WYes 2 □ No If Yes, Give Year or Dates:		Specify:	Specify:	te, etc. hite
Maryland 21215-0036	ithin 72 h ne. nen "natu n Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done dur life. DO NOT use retired)	on ring most of working	16b. Kind of Business	
2	Hygier ther th	CO	11th Grade 17. Father's Name (First, Middle, Last)		Welder	8. Mother's Name (First, Middle	Metal Fab.	rication
Jan	Aental Aental rked c	To Be	Benjamin Harrison	ı Rasnake		Tina Ba		
lary	2 short and halfs ma		19a. Informant's Name/Relationship (Ty		19b. Mailing Address (Street and	d Number or Rural Route Num	ber, City or Town, State,	Zip Code)
	1 and Health em 27		Kenny Rasnake (So) 20a. Method of Disposition	20b. Pi	924 Delray Dri	ve, Forest Hil	L. Maryland 20c. Location - City or	
POE	Pages ent of nt: If it ry or o		1 X Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	emetery, crematory or other place) Lly Hill Mem. Gd			
Baltimore,	permit. Departm Importa eny inju		21. Signature of Funeral Service License		22. Name and Address	of Facility Schimunek r Road, Baltim	Funeral Ho	mes
			23a. Part . Enter the disease, or compli	cations that caused the death		<u>-</u>		Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	dial Infarc	-tion		Onset and Death
./		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience of):			
760, <	Physicien: The law requires that the death certilicate be executed this certilicate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	icai Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	ience of):			
89	artificat ing phy e as th		IF FEMALE:					
P.O. Box	ures that the death certific signed by the attending p d be detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnal 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 Ectopic pregnancy		23d. Date of de Month	livery Day Year
_	uires that signed by Id be deta	þ	Part II. Other significant conditions con	tributing to death but not resu	liting in the underlying cause given		tobacco use contribute t	o the cause of death?
Records,	aw require is been sig 2 should t	Completed				24a. Wa		utopsy findings available
	The l	Com					formed? death?	completion of cause of
Vita Signal	sicien: certific rector,	Be	25. Was case referred to medical examiner?	lospital:	Othor	26. Place of Death (Check only		
o	g Physie ter this	n; To	27 Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury Work?	4 ☐ Nursing Home 5 ☐ He	sidence 6 Other (Spe how injury occurred	ocify)
Division of Vital	l or Attending after death. Director: After I in by the fune	Certification;	Patural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			es 2 No	(Street and Number or R	ural Route Number
2	声류는드		4 Homicide determined 29a. Certifier 1 Certifying Phys	building, etc. (Specify)	City or T	own, State)	
	To the Hospital within 24 hours a To the Funerel Completely filled	Medical	(Check only 2 Medical Examinations)	ner: On the basis of examinat and manner stated.	wledge, death occurred at the time, ion and/or investigation, in my opin	, date and place, and due to the nion, death occurred at the time	e cause(s) and manner a e, date and place, and du	s stated. e to the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier		29c. License n	number	29d. Date signed (Mon	th, Day, Year)
•	In		30. Name and address of person who co	mpleted cause of doub ///om	1) - Au 41 =	7-64350	September	6, 2006
_	10		Irene Odia	20 M.D. 1	ON Greene	St. Baltimo	re mis	21201
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signal	ture		7	

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State of Maryland / Department of Health and Mental Hygiene 2006 28480 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** MARGARET 3:37 A.M GLORIA RICHMOND 4, 2006 September /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Catonsville Baltimore Charlestown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Year) 1 □ M 2 🙀 F 77 Yrs. 218-22-7847 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show eny injury or other treumatic event, the Mudical Examiner is use to indired at 1 ☐ Yes 2 X No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane U.S.A. 21228 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No þ Specify White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Medical Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Richmond Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Richmond (brother) 3018 Abell Ave. Baltimore, Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9-8-06 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Parkwood Cemetery 21. Signature of Funeral Service, Licensee ²². Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Meymonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine law requires that the death certificate be executed sete has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 MNo Month Day 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by End-Stage Demention 1 Yes 2 No 3 Probably 4 Illinknown 24b. Were autopsy findings available prior to completion of cause of death? Anorexia 24a. Was an autopsy performed? 1 Yes 2 No 2 No 1 ☐ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Matural 5 Pending 1 | Yes 2 | No death. investigation 2 ☐ Accident filled in by the within 24 hours after deat To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ロイイ3チチ wis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Muiden Choice Lune, Catansville, mp 21228 MO 711 Bowlin Deneen 32. Registar's Signature 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

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State of Maryland / Department of Health and Mental Hygiene 200628481 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Cynthia G. Scannell KMDER le 7506 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Maltimore

If Under 1 Year If Under 24 Hrs. Janes 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Sept 24, 1922 Birthplece (State or Foreign Country) **Funeral** Months Min. 1 ☐ M 2 🔀 F Days Hours 83 214-82-9966 Yrs Director England Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Catonsville Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41 Wade Avenue 21228 deeth England Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygier Importent: if item 27 is marked other tt any injury or other traumatic event, the once. 9 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John William Brooks Elizabeth Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 Wade Avenue Catonsville, Maryland 21228 Michael S. Scannell, Son 20b. Place of Disposition (Name of complex), crematory or other place)
Baltimore
National Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/08/06 Baltimore Maryland 21. Signature of Funeral Service Licensee
Thomas Gregori 22 Name and Address of Facility Home P.A. Frederick Road Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical Examiner 17 Sequentially list conditions, if any, is away to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and & the burial-transit The law requires that the death certificate be executed and / Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending f IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Dav 4☐ Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. <u>ک</u> 1 Tyes 2 No 3 ☐ Probably 4 ☐Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hes autopsy page 2 X No 1 ☐ Yes Division of Vital 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient ၉ 1 ☐ Yes 2 The 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 □Yes 2 □ No investigation ofter death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide within 24 hours e To the Funeral C completely filled i Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check only one) To the 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) 30. Name an ddress of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature 13462 State SEP 0 8 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 4, 2006 5:45 p M Physician Raymond Milford Sherman, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 515 Walker Avenue Baltimore 8. Date of Birth (Month, Day) (Pari) 9. Birthplace (State Country) Mary Land 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min 1 □XM 2 □ F 214-18-0864 83 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Be Completed by Funeral Director MD n/a Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 515 Walker Avenue 21212 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 Noull II If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Calibrator Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Raymond Sherman, Sr. Edith ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ann C. Sparks-daughter 17530 Wesley Chapel Rd., Monkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/8/06 Parkwood Cemetery Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final **Physician** (Buce R UNG disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to include cause. Enter Underlying Cause, (Disease or injury that initiated events Examiner Dive to (unas a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physicien and I for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month signed by the aid be detached for 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 ☐ Probably 4 ☐Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an autopsy performed? certificete 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) U25205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St. Balto med R. Ley 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SEP 0 8 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene-For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 12:45 AM M Jane Satonica September 5, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Montgomery Rockville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 07/14/1935 Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 M F 71 Director 215-36-3690 VA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location raf', or itams 23a or 28e-f ehow Examiner must be notified at 10d. Inside City Limits Director MD 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11909 Rumsfield Terrace 20904-USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
snt: If item 27 ie marked other than "neturaf", or itams 23sury or other traumetic event, the Medical Examine or must Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify:White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry At Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy R. Satonica/Son 11909 Rumsfield Terrace Silver Spring, MD 20904-20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 MC remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sep 7 permit. Page Department o Important: If any injury or once. Beltsville, Maryland Chesapeake Crematory 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Rapp Funeral & Cremation Services mo1358 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Ovarian Cancer /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) igned by the attending physician and be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 ☐ Yes 2 K No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Cther: 4 □ Nursing Home 5 □ Residence 6 Mother (Specify) Hospice 1 Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA this hours after death.

uneral Director: After this
y filled in by the funeral di 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funersi C completely filled Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29 a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mitia M. Williams, DO Sept 5, 2006 H0058032 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ynthia M. Williams, D.O. Montgomery Hospice 6001 Muncaster Mill Rd, Rockville, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 8 2006 1 0 6 5 p. C. 10 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Philip R. Smith Aug 26, 2006 9:25 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8810 Walther Blvd #2023 Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 150 M 2□ F Months Yrs. Director 89 216-12**-**0151 Feb 18, 1917 Washington DC Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2√∑ No Director MD Baltimore Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8810 Walther Blvd #2023 21234 IISA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give "netural", or 1 ☐ Yes 2 X No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 accountant financia1 If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Howard Rodney Smith ပ Josephine Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Smith/spouse 8810 Walther Blvd #2023 Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ò 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Fineral Stryice Licensee Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 se, or consolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Approximate nterval Between Onset and Death Physician Bladder /Medical Immediate Cause (Final disease or condition resulting in death) months Examiner Due to (or as a consequence of) Examiner signed by the attending physician and defached for use as the bunal-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown ۵ page 2 should Completed 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Wes an autopsy performed? peen The law r Director: After this certificate has 2 1 No 1 🗆 Yes 1 ☐ Yes 2 → No Be 25. Was case referred to medical exeminer? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ٩ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation death. 1 ∏ Yes 2 ∏ No 2 Accident the within 24 hours after des To the Funeral Diractor completely filled in by th 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Dey, Year) 223111 2006 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 1312

State Registrar

Loworma

31. Date filed (Month, Day, Year)

8400

32. Registrar's Signature

Walth

21234

K 26 2006

Maryland 21215-0020

Box 68760,

Division of Vital Records, P.O.

For Amend #16a&b Per State of Maryland & Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 28, **Physician** 2006 Patsy Sutherland 9:20 AMM /Medical 4e. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner 10 8th Avenue Brooklyn Anna Arundel 5. Social Security Numberunk If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Dec 13, 19 6. Sex Birthplece (Stete or Foreign Country) **Funeral** 1 ☐ M 2 🂢 F 59 Director Dec 1946 Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or Itema 23a or 28a-f shov the Medical Exercites must be notified at MD 1 ☐ Yes 2 ₹ No Director Anne Arundel Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 8th Avenue Funeral filed within 72 hours after death 21225 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give² Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) unk16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene.
ant: If Itam 27 is marked other than iry or other traumatic event, Itam Administrative Assistant 12 Dept of Motor Vehicles 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Preston Hamilton ၉ Mary Hopkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Sutherland/friend 3005 Birch Brook Road Richmond, VA 23228 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of It 1 ☐ Burial 2 ☐ Cremation 3 ☐ Bernoval from State Important: It any injury o 4 □Donation 5 ☑Other (Specify) in state 21. Signatur of Fune II Service Licens Renald S 22. Name and Address of Facility once. State Anatomy Board 655 W. Baltimore Street Director Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician rterio sclerotic resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner flam, leading to in reclaim cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-P.O. Box 68760, Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9☐ Unknown 93√Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 Minknown 1 ☐ Yes 2 ☐ No page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 Yes 25 No or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29h. Signature and title of certifier 29c. License number 06054 son who completed cause of death (Item 23a) (Type, Print) 1//IAM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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	d.		30. Name and address of person who	completed cause of	f death (Item	23a) (Type 5	Print)	-)0	2		18			
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		1 - For State Registrar	State of Marylan	d / Departme <i>Certifica</i>	ent of Health and ate of Death	Mental Hy	giene 200	6 28487
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Funera Directo		5. Social Security Number 6. S 197-40-8465 Usual Residence of Decedent	Sex 7. Age (In yrs. I	ast birthday) If Un- Yrs. Month	der 1 Year If Under 24 H is Days Hours Mi		h y, Year) 9. 8	irthplace (State or Foreign County)
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5-0036 72 hours after death with the Marylan natural; or items 23s or 28s-f show disal Evarylinst must be notitled at	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	S. 13. Was De If Yes, s	cedent of Hispanic Origin? pecify Cuban, Mexican, Pur 20 No Specify:	(Specify Yes or No erto Rican, etc.)	Specify: (nerican Indian, nite, etc.
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Baltim permit. Pag Department Important: any injury		21. Signature of Funeral Service Lice	nsee Sills	22. Name Be7	n Cem. Sugand Address of Facility Franchis GN. CHROLLIN	Home	BAITE MID	21212
death certificate be executed death certificate be executed extending physicien and deruse as the burial-transit	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Box MARR Due to (or as a consequence of the consequence)	VFMU-00 uence of): POM FRAM uence of): ELAD LE	cclusive dis	ac or respiratory ar	rest,	Approximate Interval Between Onset and Death 2 MOMILS 3 MOMILS 1 YEAR
death certif	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3 Ectopic	pregnancy (specify)		23d. Date of d Month	elivery Day Year
ecords, P.O. law requires that the as been signed by th	by	Part II. Other significant conditions of	contributing to death but not resu	ulting in the underlying	g cause given in Part I.	1 O Y	′es 2 □ No 3 □ I	
Vital Recicion: The lavecertificete has	e Completed	25. Was case referred to medical		7500	00 Di 10	Yes	rmed? prior to death?	
on of ding Phys	ation; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury	Dthos		lence 6 ⊡Other (Sp row injury occurred	ecity)
Division transfer or attentors after death all Directors led in by the	Certification;	3 Suicide 6 Could not be determined	28e. Ptace of Injury - At ho building, etc. (Specify	me, farm, street, fact	ory, office	28f. Location (S City or Ton	Street and Number or i n, State)	Rural Route Number,
To the Hospital within 24 hours a To the Funeral I(completely filled	edicai	29a. Certifier (Check only one) Certifying Pl	nysician: To the best of my know miner: On the basis of examinat and manner stated.	wledge, death occurr ion and/or investigati	ed at the time, date and pla on, in my opinion, death oc	ce, and due to the courred at the time,	cause(s) and manner added	as stated. ue to the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier	3 As		29c. License number RES - 000		29d. Date signed (Moi	
12		30. Name and address of person who Mal Berwatt THE 31. Date filed (Month, Day, Year)	Johns MOPKINS	MOSPITAL	RES - 1000	WLFE ST	BALTIMORE	MD 21287
S Regis	tate trar	CED 0 3 2	32 Registrar's Signal	A STATES				

State of Maryland / Department of Health and Mental Hygiene 200628488 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ELSIE ELIZABETH SWINDELLS September 7, 2006 11:38 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | August 2,] Presbyterian Home of Maryland Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 🗓 F 1905 Washington D.C Yrs. Director 214-14-9795 101 Usual Residence of Decedent the Maryland or 28a-f show 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 📉 No Directo Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r then "netural", or Items 23s or the Mydical Exeminer must be r 400 Georgia Court 21204 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after and of Health and Mental Hygiene. 1 XNever Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 years Secretary Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Beaumont Swindells Martha Elizabeth Whaley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerrold Roush 1911 Clover Hill Road (nephew) Mansfield, Texas 76063 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Depertment of Importent: If eny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 9-11-06 Baltimore, Maryland 21. Signatore of Funeral Service Licenses 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21212 terran 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ASJo- he Gotc das disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) attending physicien and for use as the burial-transit death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has ormed? 1 Yes 2 No 1 Yes funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 Yes 2√ No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Hospital or Attending PI
24 hours after death.
Funeral Director: After the fulled in by the funeral 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifier 29c. License number 0 37016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 671 N. Cherly St. Set 4105 B. Han, mo 21204 Green 2 KEGUER M. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien A O C

			1 - For State Registrar	Co	ertificate of Death	Rag.	
	Physici	an	1. Decedent's Name (First, Middle, Last,			2. Date of Death Month	Day Year
	/Medic			rgerum E. Stevens	3	September	4, 2006 4:30 P ^M
	Examir	ner	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of Death
7	.	- 4	Brighton Gardens 5. Social Security Number 6. Sec	x 7. Age (In yrs. last birthda	Chevy Chase V) If Under 1 Year If Under 24 Hrs.		Montgomery
2.	Funeral Director		578 - 54 - 2783	M 2⊠F 97 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Oay, Ye October 13,	9. Birthplace (State or Foreign Country) 1908 Pennsylvania
30.5	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	Manyl t sho	0	Maryland Montgome				1 ☐ Yes 2 🕅 No
	28a	rect	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	N with	I D	5305 Worthington	Drive	20816		nited States
	death	ner			B. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		14. Race - American Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, If a Medical Exeminal most be notified at once.	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🕅 No Specify:	o Alcan, etc.)	Black, White, etc. Specify: White
5-0	72 ho	etec	15. Decedent's Edu (Specify only highest grade	cation 16a. Dec	cedent's Usual Occupation	kina 16b	. Kind of Business/Industry
121	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r traumatic event, the Media	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	re kind of work done during most of wor . DO NOT use retired) memaker		***
2	Hygie Hygie ther t		12 17. Father's Name (First, Middle, Last)	nc	γ	ne (First, Middle, Maid	wn Home
an	d be antal	To Be	Charles Jefferson	n Evans		iola Flowe	·
Maryland	shoul nd Me mark	Ĕ	19a. Informant's Name/Relationship (Ty		iling Address (Street and Number or Ru		
	nd 2 alth a 27 is		Roger A. Stevens /		Poplar Road, Orange		
Je,	s 1 a of He Item		20a. Method of Disposition	20b. Place of Dis			. Location - City or Town, State
Ē	Page nent c ant: If		1 ☐ Burial 2 XX Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	ternoval from State	Crematorium, Inc. 6, 2		thesda, Maryland
Baltimore,	permit: Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra ance.		21. Signature of Funeral Service License	98 P	22. Name and Address of Facility		nesda-Chevy Chase, Inc.
	70 5 8 0		Ungekellepan	M01303 7	557 Wisconsin Avenue,	Bethesda, Mar	ryland 20814-3501
			shock, or heart failure. List only or	ications that caused the death. Do not e ne cause on each line.	inter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Anorexia			6 Months
	Examiner			Due to (or as a consequence of): Carcinoma of th	a. Dootsum		wt 1667 (155.1
100		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of).	e Rectum		Z ₂ ledis
	cuted	Examiner	Cause (Disease or injury that initiated events		,		
oʻ	tificate be executed ig physician and as the burial-transit	Ex	resulting in death) Last	Due to (or as a consequence of):			
68760,	ate b hysic the bi	Medical		L			
_	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	/Me	IF FEMALE:	3c. If yes, outcome of pregnancy			
Вох	eath cer attendir for use	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1 Live birth 2 ☐ Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
P.0.	t the de by the s tached t	Physician/	1 ☐ Yes 2 ¥¥ No 9 ☐ Unknown	9□ Unknown	Z other (specify)		
	res that igned b be deta	by PI	Part II. Other significant conditions con	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
Records,	w require been sig should b					1 🗌 Yes	2 □ No 3 □ Probably 4 🕅 Unknown
ပ္ပ	e law re has be je 2 sho	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
æ	The laste has page	Som				performed	? death?
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?			th (Check only one)	
of	hys this al di	7	1 ☐ Yes 2 🔯 No	lospital:	ent 3 DOA Other: 4 Nursing H	ome 5 Residence	ASSISLEG 6 MOther (Specify) Living
UQ	of the day	tion	1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how in	ijury occurred
Division	Attending r death. ector: After by the fune	fica	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s		28f. Location (Street	and Number or Rural Route Number,
ο	s effer al Dire	Certification:	4 Homicide determined	building, etc. (Specify)		City or Town, St	ate)
	To the Hospital or Attendi within 24 hours effer death To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examination	sician: To the best of my knowledge, dea ner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	, and due to the cause rred at the time, date a	u(s) and manner as stated. and place, and due to the cause(s)
	withir comp	×	29b. Signature and title of certifier	1 1 2.4	29c. License number	29d. [Date signed (Month, Day, Year)
)	1		I James & M.	ocker MV3	D0037678	Sep	tember 5, 2006
	10		30. Name and address of person who co				
	1		James Mackin, M.D		Avenue, #675, Chev	y Chase, M	aryland 20815
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	A w		
DH	MH 17 Rev 1/20			1006 Jenne Bi	Grand .		
					V		

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2006

1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9:15 p. **Physician** Raymond Joshua Stockes, Jr. Month August 29, 2006 eer /Medical 4c. County of Death Howard 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Columbia 8820 Besthold Garth | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | February 9, 1942 5. Social Security Number Birthplace (State or Foreign Country)
 Virginia **Funeral** 7. Age (In yrs. last birthday) NM 2□F 64 Yrs. Director 228-52-7807 Usual Residence of Decedent the Maryland woye 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits rthen "naturef", or freme 23a or 28a-f ehov tre Medical Examiner must be notified at 1 ☐ Yes 2 No Director Columbia Howard Maryland 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filled within 72 hours after death with Department of Health and Mental Hygiene. Importent: if I tem 27 is marked other then "---' any injury or other treumeit- ans. 21045 8820 Besthold Garth Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Çuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 1 No Ď 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Florence Emmons Raymond Joshua Stockes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8820 Besthold Garth Columbia, Maryland 21045 19a. Informant's Name/Relationship (Type, Print) Wife Mrs. Joan C. Stockes 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town. State 1 Burial 2 Cremation 3 Removal from State Ellicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) St. John's Cemetery 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 21. Signature of Funeral Service Dicense 23a. Part1. Enter the disease, or com shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lymphoma Smouth /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy o Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.0. 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 ☐ Probably 4 ☐ Unknown After this certificate hes been si funeral director, page 2 should 1 Yes 2 No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 No 1□ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 KResidence 6 Other (Specify) Certification: To 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 3 ☐ Suicide 6 Could not be in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide To the Funeral Di To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1131 August of death (Item 23a) (Type, Print) Chambra MD 21044 Nichalus Keintre lates mo 1065 Little Parement Ples 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

SEP 0 8 2006

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2006 28491 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Emily Marie Shumate /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner tranklin altimore iare sedale If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 20 F Yrs. Director 30, 2006 Maryland Aug. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Directo Pennsylvania York Airville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7830 Woodbine Road death by Funeral 17302 USA . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Sarah Marie Jimmie Howard Shumate Canneti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jimmie H. Shumate / Father 7830 Woodbine Rd., Airville, PA 17302 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bapt. View Church Cem. 9-8-06 Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. Rucol 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** prematur Norreme /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical SIS the 25 attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐Unknown 1 ∏Yes 2 ∏No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate hes birector, page 2 s autopsy performed? 1□ Yes 2 🔯 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 1 ⊠Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 120 Haxch who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) SEP 0 8 2006 32 Registrar's Sig State Registrar

Amend #10c Please Type 35 Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Amend #1 Per ME C859 9/11/06 Hertificate of Death

Reg. No. 200 Dayle Ann 1. Decedent's Name (First, Middle, Last) Sullivan 2. Date of Death 3. Time of Death Month 1038 AM **Physician** 2004 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner HOWARD OCUMBIA If Under 1 Year | If Under 24 Hrs. | 8 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 □ M 2 🗙 F 57 133-40-1144 Director 8/30/49 NY Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23a or 28a-f ehow other treumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No - Columbia Elkridge Director Howard County 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21075 USa 8005 Greentree Court Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 200 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) disabled disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ Edward Campbell Faye 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Thomas Sullivan 8005 Greentree Court, Elkridge, MD 21075 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
eny injury or ot 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory 9/05/06 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, MD 22. Name and Addrass of Facility Cary L. Kaulman Funeral Home @ MMP, Inc. 7250 Washington Blvd., Elkridge, MD 21075 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): LEROTA CADDION ASCUM Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): physicien s the burial Box 68760, Physician/Medical attending for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) ed by the a detached f o 9 Unknown 9 Unknown ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be o Records, 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed2 l director, page 2 No 1 ☐ Yes 2 1 No 1 TYes Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1☑ Yes 2☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ER/Outpatient 3□ DOA 1 Inpatient 2 ð nours after death.

neral Director: After this filled in by the funeral d 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year)

Registrar

State

31. Date filed (Month, Day, Year)

SEP 0 7 2006

MATOCARTRE

s of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2.2.0

		1 - For State Registrar		aryland / L	Certificate of	Death		Reg. No.	
Physici		Decedent's Name (First, Middle Nancy Teusche	,				2. Date of Dea	, Day Y	3. Time of Death
/Medi		4a. Facility Name (If not institution,		1	4b. City, Town,	or Location of Dea	Augus	4c. County of	76
		SINAI HOSPIT	ALOF BAL	TIMORE	BALT	MORE			
Funeral Director		5. Social Security Number 229-16-9000 Usual Residence of Decedent	6. Sex 7. Ag 1 ☐ M 2 ∏ F	ge (In yrs. last bir 84	thday) If Under 1 Year Months Days			h y, Year) 1922). Birthplace (State or Foreig Country) Virginia
/land		10a. State 10b. County		10c. City, Tow	or Location				10d. Inside City Limits
Many Fied	Funeral Director	MD Balti	more	Tot	/son				1 ☐ Yes Man
th with the 23a or 28		10e. Street and Number 204 E. Joppa F	load #307		10f. Zip Code	2128	36	10g. Citizen of Wh	at Country? USA
and 21215-0036 be filed within 72 hours after death with the Maryland hall Hygiene. d other than "natural", or items 23s or 28s-f show event, the Medical Examinat must be notified at	þ	11. Marital Status 1 □ Never Married 2 ☑ Marri 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? ad 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?	13. Was Decedent of If Yes, specify Cub		Specify Yes or No to Rican, etc.)		American Indian, White, etc. White
5-0 72 hc	Completed	15. Decedent (Specify only highes	s Education grade completed)	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of wo	orking	16b. Kind of Busi	ness/Industry
T2	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)				orm he	·m 0
O B D B T	ပိ	12 17. Father's Name (First, Middle, I	ast)		housew		me (First, Middle,	own ho	
Maryland 212' the and Mental Hygiene. To the marked other than traumatic event, the Me	To Be	Jerry Mauric				Ann	ie Reyno	lds	
shou and M	-	19a. Informant's Name/Relationsh	ip (Type, Print)	19b	. Mailing Address (Street	t and Number or A	tural Route Numbe	er, City or Town, St	ate, Zip Code)
ond 2 salth a salth a r 127 is		William Teusche	c/spouse	20	04 E. Joppa	Road #30	7 Towson	n, MD 21	286
Baltimore, Marylar permit. Pages 1 end 2 should be Department of Health and Menta important: If tiem 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (Sp		comoto	Disposition (Name of ry, crematory or other pla	nce)	Date	20c. Location - C.	ity or Town, State
Dairi. Departitimports any inju		21. Signatur 1 Everal Service I	. Wade, Dir	ector	State Anat Baltimore,			Baltimo	re Street
		23a. Part1. Enter the disease, of shock, or heart failure. List	complications that cause	d the death. Do				rest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition metastate amounts are							
/Medical		resulting in death)	Due to (or as	a consequence					7.90
Examiner	_	Sequentially list conditions,	b	u universitation	40				
ed isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
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68 / 60, ificate be exi g physician as as the burtal	alE		d						
68 tificati g phy as th	ledical								
Attending Physician: The law requires that the death certificate be executed reach. I death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	ey .		23d. Date Monti	•
uires that the signed by tid be detact		Part II. Other significant condition	ns contributing to death b	but not resulting i	n the underlying cause g	ven in Part I.			ute to the cause of death?
RECORDS Blaw require hes been signed 2 pe 2 should 1							24a. Was		ere autopsy findings availab or to completion of cause of
The The Page	ĕ						perfo	rmed? de	ath? ☐ Yes 2 ☐ No
ysician: The l ysician: The l is certificete he director, page	Be (25. Was case referred to medical examiner?					eath (Check only o	ne)	
of V hysic this c	은	1☐ Yes 2☑ No	Hospital: 1 Dinpati		ILPALIBITE 3 DOA			dence 6 □Other	· · · · · · · · · · · · · · · · · · ·
On of ding Phys	<u></u>	27. Manrer of Death 1 ■ Natural 5 □ Pending	28a. Date of Inju (Month, Da	ury 28b. ay Year)		ork?	28d. Describe I	now injury occurred	1
isio kttendi death. ctor; A y the fu	icat	2 Accident investigation M 1 Yes 2 No						or Bural Bouto Number	
Division of Vital Records, To the Hospital or Attending Physician: The law requires twithin 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be of	Certification:	4 Homicide determined building, etc. (Specify)							
• Hosp 124 hou • Fune (etely fi	Medicai	29a. Certifier 1 Certifyin (Check only 2 Medical I	g Physician: To the best examiner: On the basis of and manner st	of examination ar	e, death occurred at the t id/or investigation, in my	ime, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	0 1		29c. Licen	se number		29d. Date signed (Month, Day, Year)
		1	Hu,	MD	R	55001	0	August	31,2006
		JASON Hu, MD	who completed cause of	death (Item 23a)	(Type, Print)	401 W. BE	ELVEDERE A	VE. BALT	31,2006 11,2006 11MORE, MD 212
	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	8 D.				
Regist	rar		2006	was the	STORAGE !				
DHMH 17 Rev 1/2	2001	SFAG) LOOO Jacob			•			

ORIGINAL

Please Type or Print in Black Indelible Ink

ITON Edwin 18		1- For State Registrar	Certificate o		R	eg. No. 2006 2849	
Physici edical Exam		1. Decedent's Name (First, Middle,Last) CUFTON E . TAYLOR			2. Date of Dea Month Sentember	Day Year er 4, 2006 3. Time of Death	
1		4a. Facility Name (if not institution, give street and numbe	r)	4b. City, Town, or Location		4c. County of Death	
Funeral		211 Grove Park Road 5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)	Baltimere If Under 1 Year If Und	Brooklyn Mer 24Hrs. 8. Date of Bi	Anne Arundel rth(MM/DD/YYYY) 9. Birthplace (State or	
Director		220 · 52 · 6910 1 M 2 F Usual Residence of Decedent	54 Yrs	Months Days Hour		Foreign	
' any	tor	10a. State 10b County	10c. City, Town or Local	tion		10d. Inside City Limits	
land f show		MD NA	BALTIMORE			1 Yes 2 No	
e Mary or 28a	Director	10e. Street and Number		10f. Zip Code		Og. Citizen of What Country?	
72 hours after death with the Maryland n"matural", or items 23a or 28a-f show any al Examiner must be notified at once.	ral	211 GROVE PARK ROAD 11. Marital Status 12. Was Deceder		21225 as Decedent of Hispanic Ori		2- 14. Race - American Indian, Black,	
death	Funeral		5? If Y 2	es, specify Cuban, Mexicar	n, Puerto Rican, etc.)	White, etc.	
ırs afteı ural",	by	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade co	mpleted) 16a, Deceder	Yes 2		Specify: BLACK 16b. Kind of Business/Industry	
5 72 hou in "nat	letec	Elementary/Secondary (0-12) College (1-4 or	during m	nost of working life. DO NOT		is the or business/maustry	
within giene her tha	Completed	8 TH GRADE NA 17. Father's Name (First, Middle, Last)	12	UCK DRIVER	da Nama /First Middle	GAS DELIVERY	
D 21215-0036 should be filed within 72 hours after and Mendal Hygiers 17 is marked other than "natural". It is marked other than "natural".	Be	CLIFTON TAYLOR	T 100 10 10	BERA	r's Name (First, Middle,	,	
MD 2 d 2 should. Ith and M n 27 is m	To	19a. Informant's Name/Relationship (Type, Print) SOAN N. IILLMAN (DAUGH)	N		mber or Rural Route Nur	mber, City or Town, State, Zip Code)	
		20a. Method of Disposition 1 K Burial 2 Cremation 3 Removal from S	20b. Place of Dispos	sition (Name of cemetery	Date	20c. Location - City or Town, State Balto.Md. 21227	
Baltimore, remit. Pages I ar Department of Hee mportant: If ite njury or other tr		4 Donation 5 Other Specify:	GLEN HAY	EN	09.11.06	GLEN BURNIE , MD	
Baltimo permit. Page Department of Important: injury or oth		21 Signature of Funeral Service Licensee	VAI	Name and Address of Facility JGUN C. GREE	NE FUNERAL	SERVICE	
Physician		23a. Part Enter the disease, or complications that cause failure. List only one cause on each line.	d the death. Do not enter t	he mode of dying, such as o	cardiac or respiratory arr	rest, shock, or heart Approximate Interval Between Onset and	
/Medical xaminer	Immediate Cause (Final disease a. Hypertensive atherosclerotic cardiovascular disease						
and the second s		or condition resulting in death) Due to (or as a con Sequentially list conditions,	sequence of);				
	iner	if any, leading to immediate Due to (or as a con cause. Enter Underlying Cause	sequence of):				
sd sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a con	sequence of):				
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760, cate be physici he buni	Medical	IF FEMALE: 23c. If yes, outcome	tem#4b,23a,2/,pome of pregnancy	erME,6859,9/18/0	06 T	23d. Date of delivery	
Box 687 e death certific the attending I ed for use as the	cian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant a	at time of death	etal death 3 Ectopi	ic pregnancy	Month Day Year	
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Division of Vital Records, rate dearneds and returning Physician: The law requirement and brector. After this certificate has been sited in by the funeral director, page 2 should be	omp				autop perfo 1 ✓ Yes	rmed? death?	
tal Relan: 1 certific ector, p	Be C	25. Was case referred to medical examiner?		26.Place of Death	(Check only one)		
fVi Physic er this eral dir	ပ	1 Yes 2 No No Inospital 1 Inpat	ient 2 ER/Outpatient			Residence 6 Other: Scene	
on of \ ending Phy ath or: After tl	tion	1 X Natural 5 Pending (Month, Day	Year)	1 Yes 2	_	now injury occurred	
ivisi or Att after de Direct	Certification:	Suicide Could not be	njury - At home, farm, stre	et, factory, office building, e		Street and Number or Rural Route Number, City	
Ospital ospital hours uneral ly fillec	and series of the first se						
To the II within 24 To the F complete	Medical	one) 2 Medical Examiner: On the basis of examiner stated	amination and/or investiga				
29c. License number 29d. Date signed (Month, Day,							
		Caralulades		O.C.M.E.		September 5, 2006	
		 Name and address of person who completed cause of Laron Locke MD. Assistant Medical Ex 	, ,	Street, Baltimore, M	1D 21201		
S Regis	tate trar	31. Date filed (Month, Day, Year) 32 Registr	ar's Signature	de la			

State of Maryland / Department of Health and Mental Hygien 2006 28495 1 - State Registrar Certificate of Death Rag. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OPAT TESTER SEPTEMBER 5, 2006 6:15 A. M. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May11,1923 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. Hours 1 □ M 2 T F 83 219-20-9075 Director Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ral', or Items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits MD Director Baltimore Middle River 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 113 Compass Road 21220 USA filed within 72 hours after death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: White 3 ☐ Widowed 4 ☑ Divorced "natural" al Hygiene. I other than "nature ivent, the Madical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill thent of Health and Mental H tant: If item 27 is marked other. Be Calvin H. Gore HAttie Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Tester /son 803 Coconut Belair MD 21014 item 27 other t 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Holly Hill Cemetery 9/8/06 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 permit. Page Department of Important: If any injury or once. Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave.Balto.MD 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one ons that caused the death. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line Immediate Cause (Final disease or condition resulting in death) presu **Physician** Quemon /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to him editor cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Duality (or as a consequence of) To the Hospital or Attending Physicien: The law requires thet the death certificate be executed the burial-transit Due to (or as a consequence of) Completed by Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 DEctopic pregnancy ŏ Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached t 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Was a... autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral: 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D3225K 0 September 5,201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID DUNN 615 W. MACPHAIL ROAD - BEL AIR, MD. 21014

State Registrar

31. Date filed (Month, Day, SEP ()

Division of Vital Records, P.O. Box 68760,

2. Registrar's Signature

				State of Maryland	/ Dep	artment of H	lealth and M	lental Hygie	•	28496																		
			Registrar		Ce	rtificate of	Deam		. NoZ. U U U	3. Time of Death																		
-	Physici /Medic		1. Decedent's Name (First, Middle, Last) MATTIE	M. THU	RM	T		2. Date of Death Month SEPTEMBE		6 8:43 PM																		
	Examin	er	4a. Facility Name (If not institution, give sind IQ No. BRUCE	STREET		0	r Location of Death		4c. County of Deal	ih																		
	Funeral Director		5. Social Security Number 6. Sex 10	7. Age (In yrs. las	st birthday, Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y SUNE 6)	(ear) Co	thplace (State or Foreign nuntry) BAMA																		
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	ath with	Funeral Director	12 N. BRUCE			2120			J.S.A.																			
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21215-0	within 72 ene. then "net	Be	Be	Be	o Be Completed	Be	To Be Completed	Be	ompleted	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	ing	Sb. Kind of Business	•											
Maryland 2	buld be filed Mental Hygis arked other atic event, I								17. Father's Name (First, Middle, Last) HENRY	ALLBRIT	TOP	J	18. Mother's Nam	e (First, Middle, Ma	uiden Sumame) HART	LEY												
Mary	od 2 shoulth and h		19a. Informant's Name/Relationship (Type) QUEEN BYAS	(DAUGHTER)					City or Town, State,																			
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 Surial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	20b. Pla	ce of Disp netery, cre UTUS	osition (Name of matory or other pla M2MORIAL	ce) LAARK 09-1	3-2006 B	oc. Location - City or	Town, State																		
Balt			21. Signature of Funeral Service License	N. Willian	2 3	2. Name and Address OSEPH H	SS of Facility BROWN	JTR. FL	NERAL MORE, MD	HOME 21217																		
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89	eath certificate be exattending physician for use as the buria		IF FEMALE:	Sc. If yes, outcome of pregnance																								
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al Re		Completed	Coloneo 9 M	100	CCV			autopsy performe 1 ☐ Yes 2	prior to death?	completion of cause of																		
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:	D/O : .:	Ott	205	h (Check only one)																				
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sion	Attending F r death. ector: After by the funer	catlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1	Yes 2□No																					
Division	el or Attenus after deatl	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, si	reet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,																		
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	To the within 2 To the comple	Me	29b. Signaturand title of pertifier	Pollos	m	29c. Licens	se number	290	d. Date signed (Mon	th, Day, Year)																		
	1		30. Name and address of person who co	mpleted cause of deat (I)-m	23a) (Type	, Print)	54 149		11/1/2	UUW BALFAMON																		
	<u> </u>		HITEN KE	114 MD. 4	Ch	51, KO1.	ling Ch	055601	AS5, 541	FE 311 2122																		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 28497 1 - For State Registra Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 4, 2006 **Physician** Ruth Virginia Turner 10:30P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital N/A Baltimore Hours Min. Matter 13, 1914 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 1 M 2 X X Months Days Vfrainia 217-20-0156 92 Yrs. Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. Count wode ir then "naturel", or items 23a or 28a-f ehoving Medical Examiner must be nutified at XX Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 840 Glenwood Avenue 21212 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: ģ 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Baker Bakerv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked of Walter Robert Posey Mamie Virginia King es 1 and 2 should be of Health and Menti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene F O'Neill DTR 67 Arverne Court Timonium Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
eny injury or ot XX Burial 2 Cremation 3 Removal from State 9/8/06 Baltimore National Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the dishase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 2 hours MMOUNTON disease or condition resulting in death) /Medical Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as attending | 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for o 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 FR/Outpatient 3 DOA within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ŏ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and Me of certifier Print) Septem Suite 34 Towson M W of person who completed cause of death (Item 23a) (Type, Print) TURNOR MO

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Important: If item 27 ie marked other than "natural", or items 23s or 28s-f show eny injury or other traumatic event, the Medical Examinar must be notified at once.

Susan C Vanderwende Baltimore, Maryland 21215-0036 Physicia /Medica Examine

Funeral

rnysician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

•	1- State of Marylan	•	artment of Health and I		ne 2006	28498				
	Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death				
n II	Susan C. Van Der Wende			September						
r	4a. Facility Name (If not institution, give street and number). The Memorial HOSP				4c. County of Death Talkot					
	5. Social Security Number 157–36–9862 6. Sex 1 □ M 2 □ F 7. Age (In yrs. 58)	last birthday, Yrs.	If Under 1 Year Il Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye May 31, 1	th, Day, Year) Country)					
	Usual Residence of Decedent 10a. State 10b. County 10c. Cit	ocation			10d. Inside City Limits					
jo	MD Queen Anne's C		1 ☐ Yes 21 No							
Funeral Director	10. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?					
era	101 Weedon Street 11. Marital Status 12. Was Decedent Ever in U	21617 Was Decedent of Hispanic Origin? (Si	pecify Yes or No-	USA 14. Race - American Indian,						
	1 Never Married 2 Married 1 Yes 2 No If Yes, Give		Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	o Rican, etc.)	etc. nite					
e D	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education	16a. Dece	edent's Usual Occupation	166	. Kind of Business/Ir					
Completed by	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	e kind of work done during most of won DO NOT use retired)	king		,				
ទី	12 2 17. Father's Name (First, Middle, Last)		bookkeeper	ne (First, Middle, Maid						
o ge	Harold G. Larson			Gertrude						
-	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street and Number or Ru			o Code)				
	Richard Van Der Wende/spouse		l Weedon Street Ce							
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)	lace of Displemetery, cre	osition (Name of imatory or other place)	Date 20c	Location - City or To	own, State				
	21. Si nature of Euneral Service Licensaer Royald S. Wale Director		2 Name and Address of Facility tate Anatomy Board altimore, MD 2120		altimore S	Street				
T	23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart lailure. List only one cause on each line.					Approximate Interval Between				
	Immediate Cause (Final disease or condition	mediate Cause (Final sease or condition wetastate colon can ver								
	Due to (or as a conseq	sulting in death) Due to (or as a consequence of):								
Je	Sequentially list conditions, fany, leading to inmediate cause. Enter Underlying Cause (Disease or injury									
Examin	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the c	neuce of):								
dical E	d									
ō					F					
Pnysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ✓ Yes 2 ✓ No 9 Unknown 23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year				
Dy Pr	Part II. Other significant conditions contributing to death but not res	ulting in the u	underlying cause given in Part I.	23e. Did tobacc	co use contribute to t	he cause of death?				
	Hypothyroldism: Hy	BS1 }	noisny	1 ☐ Yes	2 □No 3 □ Prol	pably 4 XUnknown				
Completed	24a. Was an autopsy lindings availa autopsy prior to completion of cause performed? death? 1 □ Yes 2⊠No 1 □ Yes 3⊘□ No									
0	25. Was case referred to medical	112.	26. Place of Dea	1 ☐ Yes 2 ☑ th Check only one	10 100	30,10				
0	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA Other: 4 Nursing H	ome 5 Residence	e 6 ☐Other (Specia	(y)				
2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)										
edical Certification:	29a. Certifier (Check only one) 1.2 Certifying Physicien: To the best of my knot 2 Medical Exeminer: On the basis of examina and manner stated.	wledge, deal tion and/or in	th occurred at the time, date and place, nvestigation, in my opinion, death occur	, and due to the cause rred at the time, date	e(s) and manner as s and place, and due to	stated. the cause(s)				
Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)									
	MO MO		D63726	0	9.02.	2006				
	30. Name and address of person who completed cause of death (Item MAJEISS DUNMI	23a) (Type,	NMI. EAST	4720	NO CN	(100).				
e r	31. Date liled (Month, Day, Year) SEP 0 8 2006	ture A	all							
	2Fh n O Thon Walker	1								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 28499 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Sept. 7 Daz 2006 Year Lucille Mary Vogel 8:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 38 Riverside Road Essex | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | April 123, 1920 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 □ MF 213-09-8707 86 Director Usual Residence of Decedent wode 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-f show other treumatic event, the Modical Examinar must be notified at Director MD Baltimore Essex 1 ☐Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 38 Riverside Road USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married .0 1 ☐ Yes 2 No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 ! Hygiene. Sue's Doll House Elementary/Secondary (0-12) College (1-4or 5+) Owner es 1 end 2 should be filed w of Health and Mental Hygier filtem 27 is marked other th 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Howard Wimbley Julia Dickerson ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Vogel /husband 38 Riverside Road Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 20c. Location - City or Town, State Ξ ö 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of importent: if eny injury or once. Baltimore MD OAk Lawn Cemetery 9/11/06 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 300 MAce Ave.Balto. MD 21. Signature of Funeral Service Licen Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** Alzheimeris disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executs.) Examiner Due to (or as a consequence of): attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 No 1 Yes ₽No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 🗌 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

The taw requires that the death certificate be executed Division of Vital Records, or Attending Physician: this To the Funeral Director: After th completely filled in by the funeral death. within 24 hours after deat To the Funeral Director: To the Hospital

72 hours after

Maryland 21215-0036

Baltimore,

Box 68760,

P.O.

State Registrar 29b. Signature and title of certifier

holdon 31. Date filed (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. (ner, M) 91. 8 2006 32. Registrar's Signature

DHMH 17 Rev 1/2001

9110 Philadelphia Rd

29d. Date signed (Month, Day, Year)

		r ieuse i	State of Mary					-	_	Die.		
		1 - For State Registrar	State of Mary		Certifica				1eg. No 20	06	28500	
		Decedent's Name (First, Middle, Last,)		1./			2. Date of Dea Month		Year	3. Time of Death	
Physici /Medic		Kopert			Va	ule	f	Septem	bers, o	2006	01:06 PM	
Examin		4a Facility Name (If not institution, give	111	1 1	4b. City	, Town, or Lot		th	4c. County	of Death		
		5. Social Security Number 6. 56	PKINS HO	OSPITO	nday) If Unde		nore C Under 24 Hr		1	9. Birthn	lace (State or Foreign	
Funeral Director			² M ² □F 68	-	rs. Months	Days H	lours Mir	0 ck 16	, Year) 937	Mary	land	
P .		Usual Residence of Decedent	10	c. City, Town	or Leasting						0d. fnside City Limits	
lanylar show	'n	Md. Harf		c. City, Town	or Location	Fallst	on			'	1 Tes 2 No	
the N	Director	10e. Street and Number			10f. Z	ip Code			10g. Citizen of V	Vhat Cour	ntry?	
1215-0036 within 72 hours after death with the Maryland ene. then "natural", or Items 23s or 28s-f show the Mudical Exercitive rivest be rectified at		1700 Watervale Ro	ad			21047	7		U.S	.A.		
deat	Funeral	11. Maritaf Status	12. Was Decedent Eve Armed Forces?	r in U.S.	13. Was Dece If Yes, sp	edent of Hispa	nic Origin? (Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Rac Bfac	e - Americ	an Indian, etc.	
36 s after or h	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 🗆 Yes		pecify:		Specify	rah -		
-00-	ed b	15. Decedent's Edu		16a.	Decedent's Us	ual Occupation	า		16b. Kind of Bu	usiness/Inc	dustry	
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Maryland 21215-0036 td 2 should be filed within 72 hours af th and Mental Hygiene. 27 is marked other than "naturel", or traumatic event, the Mydical Exact	Be	17. Father's Name (First, Middle, Last) Robert M. Varley						ame (First, Middle, • Derenie		.e)		
irylic should nd Men mark matic	ဥ	19a. Informant's Name/Relationship (7)	vpe, Print)	19b.	Mailing Addres	s (Street and	Number or F	Rural Route Numbe	r, City or Town,	State, Zip	Code)	
Ma nd 2 salth ar alth ar 27 is r trau		Joanne Varley/wif		17	00 Wat	ervale	Road,	Fallston	, MD 21	047		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28a-1 show any njury or other traumatic event, the Mudical Examination in celling at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 F			Disposition (Na r, crematory or			Date	20c. Location -			
Page ment ment ant: if		4 □ Donation 5 □ Other (Specify)		Holy Ro	sary C			/2006	Baltimo			
Balt permit. Depart Import		21. Signature of Funeral Service Licens	99		22. Name a	and Address o munek	f Facility Funera	1 Home of	Bel Ai	r, I	nc.	
40244		23a. Part1. Enter the disease, or compl	lications that caused the	e death. Do n	610	W. Mac	Phail	Road, Bel	Air, M	id. 2	Approximate	
Dhysisian		shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.	i		-	_				Interval Between Onset and Death	
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68 rtificat ng phy as th		IF FEMALE:						THE PROPERTY APP	ONES BY			
, P.O. Box 6 that the death certif ed by the attending detached for use at	by Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death	3 Ectopic			JOH KPP	23d. Dat Mo	te of delive	Day Year	
O. He de the shed fe	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tim 9□Unknown	e of death	5 Other (s	specify)		CATTE ATT				
P.O.	y Ph	Part II. Other significant conditions co	ntributing to death but n	ot resulting in	the underlying	cause given ii	n Part I.			ribute to th	ne cause of death?	
Division of Vital Records, P.O. Box 68 at or Attending Physician: The law requires that the death certifical after death. Interest that the death certifical physicians that the attending physicians that the funeral director, page 2 should be detached for use as the director of the funeral director, page 2 should be detached for use as the director of the funeral director.								1□Y	es 2 No	3 🗆 Prob	ably 4 Unknown	
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on rth. : After	ition	1 □Natural 5 □ Pending 2 ☑ Accident investigation	8/3/06	ea <i>r)</i> Ir	OU PAN	28c. Injury at Work? 1 ☐ Yes	2 (No	Suhle	ct fel	1		
ViS.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	- At home, far		ory, office		28f. Location (S	Street and Numb	er or Rura	a fer vale Rd	
ital or rai Dii			Re	esden				I ra	11ston 1	YD	1/2	
Hosp 24 hou Fune fely fil	Medical	29a. Certifier 1 1 Certifying Phy (Check only 2 Medical Exami	rsician: To the best of m iner: On the basis of ex	amination and	, death occurre Vor investigation	d at the time, on, in my opinion	date and place on, death oc	ce, and due to the courred at the time, o	cause(s) and ma date and place,	nner as st and due to	tated. the cause(s)	
Division of To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.	Mec	29b. Signature and title of certifier	and manner stated		2	9c. License nu	ımber		29d. Date signe	d (Month,	Day, Year)	
F 5 F 0		1 Charlet	m Di	1),		RES	-00	0	Sentem	ber	5 7006	
10		30. Name and address of person who o	f -	h (Item 23a) (Type, Print)				COTON		5,2006	
(0		Leo Hsiao	600 N. h	Jolfe	St.	Balti	more	MD	2128	7		
Sta Regist		31. Date filed (Month, Day, Year) SFP 0 8 2	32. Registrar's	Signature	Span	مين						